State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Email: hsda.staff@tn.gov

CERTIFICATE OF NEED APPLICATION

1A. Name of Facility, Agency, or Institution

Heritage Hospice and Palliative Care LLC
Name

2120 Northgate Park Lane
Street or Route

Hamilton County
County

Chattanooga
City

TN
State

37415
Zip

To be developed
Website Address

Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.

2A. Contact Person Available for Responses to Questions

Michael Brent
Name

Counsel
Title

Bradley Arant Boult Cummings LP
Company Name

mbrent@bradley.com
Email Address

1600 Division Street, #700
Street or Route

Nashville
City

TN
State

37203
Zip

Attorney for Owner
Association with Owner

(615) 252-2361
Phone Number

3A. Proof of Publication

Attach the full page of newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent. (Attachment 3A)

Date LOI was Submitted: June 12, 2023

Date LOI was Published:

• Bledsoe, Bradley, Grundy, Hamilton, Marion, McMinn, Meigs, Polk Rhea, Sequatchie (Chattanooga Times Free Press)	June 15, 2023
• McMinn, Monroe (Knoxville News-Sentinel)	June 15, 2023

4A. **Purpose of Review** *(Check appropriate box(es) – more than one response may apply)*

X Establish New Health Care Institution
☐ Addition of a Specialty to an Ambulatory Surgical Treatment Center (ASTC)
☐ Change in Bed Complement
X Initiation of Health Care Service as Defined in §TCA 68-11-1607(3) Specify: **In-Home Hospice**
☐ Relocation
☐ Initiation of MRI Service
☐ MRI Unit Increase
☐ Satellite Emergency Department
☐ Addition of ASTC Specialty
☐ Initiation of Cardiac Catheterization
☐ Addition of Therapeutic Catheterization
☐ Establishment/Initiation of a Non-Residential Substitution Based Opioid Treatment Center
☐ Linear Accelerator Service
☐ Positron Emission Tomography (PET) Service

Please answer all questions on letter size, white paper, clearly typed and spaced, single sided, in order and sequentially numbered. In answering, please type the question and the response. All questions must be answered. If an item does not apply, please indicate "N/A" (not applicable). Attach appropriate documentation as an Appendix at the end of the application and reference the applicable item Number on the attachment, i.e. Attachment 1A, 2A, etc. The last page of the application should be a completed signed and notarized affidavit.

5A. **Type of Institution** *(Check all appropriate boxes – more than one response may apply)*

☐ Hospital (Specify): ____________________
☐ Ambulatory Surgical Treatment Center (ASTC) – Multi-Specialty
☐ Ambulatory Surgical Treatment Center (ASTC) – Single Specialty
☐ Home Health
X Hospice
☐ Intellectual Disability Institutional Habilitation Facility (ICF/IID)
☐ Nursing Home
☐ Outpatient Diagnostic Center
☐ Rehabilitation Facility
☐ Residential Hospice
☐ Nonresidential Substitution Based Treatment Center of Opiate Addiction
☐ Other (Specify):____________________

6A. **Name of Owner of the Facility, Agency, or Institution**

Tywanna Hamilton
Name
2120 Northgate Park Lane, Suite 303
Street or Route
(205) 962-5485
Phone Number
Chattanooga
City
TN
State
37415
Zip

7A. Type of Ownership of Control *(Check One)*

☐ Sole Proprietorship
☐ Partnership
☐ Limited Partnership
☐ Corporation (For Profit)
☐ Corporation (Not-for-Profit)
☐ Government (State of TN or Political Subdivision)
☐ Joint Venture
X Limited Liability Company
☐ Other (Specify):______________________________

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's website at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx. If the proposed owner of the facility is government owned must attach the relevant enabling legislation that established the facility. (Attachment 7A)

Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.

RESPONSE:

The Applicant, Heritage Hospice and Palliative Care LLC, is a newly formed hospice agency with an ownership type of Limited Liability Company. The Applicant entity is solely owned by Tywanna Hamilton. The Applicant will be self-managed. **Attachment 7A** includes the Applicant's organizational chart, Articles of Organization, certificate of existence and documentation from the State of Tennessee's website denoting the LLC's active status.

8A. Name of Management/Operating Entity *(If Applicable)*

Not Applicable
Name

Street or Route **County**

City **State** **Zip**

Website Address

For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract. (Attachment 8A)

9A. Legal Interest in the Site

Check the appropriate box and submit the following documentation. (Attachment 9A)

The legal interest described below must be valid on the date of the Agency consideration of the Certificate of Need application.

☐ Ownership (Applicant or applicant's parent company/owner) – Attach a copy of the title/deed.
X Lease (Applicant or applicant's parent company/owner) – Attach a fully executed lease that includes the terms of the lease and the actual lease expense.
☐ Option to Purchase - Attach a fully executed Option that includes the anticipated purchase price.
☐ Option to Lease - Attach a fully executed Option that includes the anticipated terms of the Option and anticipated lease expense.
☐ Other (Specify) ____________________________________

10A. Floor Plan

If the facility has multiple floors, submit one page per floor. If more than one page is needed, label each page. (Attachment 10A)

- Patient care rooms (Private or Semi-private)
- Ancillary areas
- Other (Specify)

RESPONSE:

The entire leased space of 2,257 square feet will serve as an administrative office for operation of the hospice. Patient care activities will take place in the patient's home and no patient care activities will be provided at the hospice agency's office location. A floor plan of the space is included as **Attachment 10A**.

11A. Public Transportation Route

Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients. (Attachment 11A)

RESPONSE:

The office location at 2120 Northgate Park Lane, Chattanooga, TN in Hamilton County is positioned just off Hixson Pike just north of Northgate Mall Drive. The location is less than one-quarter mile from Tennessee State Route (SR) 153. SR 153 serves as a bypass around downtown Chattanooga for I-75 travelers heading towards US 27 north. It is also an important route for drivers from Soddy-Daisy, Hixson, and other parts of northwestern Hamilton County who are heading for I-75 and the eastern half of the county. Hamilton County is the most populous county and central to the ten county Service Area. Regarding access to the proposed site, hospice services will not be provided at the hospice agency's office location. Rather, the office serves as a place for staff to perform their responsibilities. Patients/clients will be cared for in their place of residence with the clinicians traveling to the patient's home. Clinicians will have access to remote technology which will be used for patient documentation as well as education and communication with the administrative office.

Notwithstanding that patients do not go to Heritage Hospice's office, Chattanooga Area Regional Transportation Authority (CARTA) Route 16 passes Northgate Park Lane. A map depicting Route 16 is included in **Attachment 11A**.

12A. Plot Plan

Unless relating to home care organization, briefly describe the following and attach the requested documentation on a letter size sheet of white paper, legibly labeling all requested information. It **must** include:

- Size of site (in acres);
- Location of structure on the site;
- Location of the proposed construction/renovation; and
- Names of streets, roads, or highways that cross or border the site.

RESPONSE:

The project is an in-home hospice organization, therefore a plot plan is not applicable.

13A. Notification Requirements

- TCA §68-11-1607(c)(9)(B) states that "... If an application involves a healthcare facility in which a county or municipality is the lessor of the facility or real property on which it sits, then within ten (10) days of filing the application, the applicant shall notify the chief executive officer of the county or municipality of the filing, by certified mail, return receipt requested." Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

  ☐ Notification Attached　　　　**X** Not Applicable

- TCA §68-11-1607(c)(9)(A) states that "... Within ten (10) days of the filing of an application for a nonresidential substitution based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of the municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution based treatment center for opiate addiction has been filed with the agency by the applicant."

  ☐ Notification Attached　　　　**X** Not Applicable

EXECUTIVE SUMMARY

1E. Overview

Please provide an overview not to exceed **ONE PAGE** (for 1E only) in total explaining each item point below.

- Description: Address the establishment of a health care institution, initiation of health services, and/or bed complement changes.
- Ownership structure
- Service Area
- Existing similar service providers
- Project Cost
- Staffing

Response - ITEM 1E: Overview

Description: By way of this CON Application, Heritage Hospice seeks to fill an identified underserved need in Southeast Tennessee related to the disparity of in-home hospice services for the area's Black population. Although the Black population will be its primary focus to mitigate racial disparities, the Applicant will admit all eligible persons seeking admission regardless of race or ethnicity and will serve all patients equally. The hospice agency's office will be located at 2120 Northgate Park Lane, Chattanooga, TN in Hamilton County. Hamilton County is central to the Service Area, the most populous county in the Service Area and with the greatest count and proportion of Black population.

Ownership Structure: Heritage Hospice and Palliative Care LLC ("Heritage Hospice" or "Applicant") is solely owned by Tywanna Hamilton and formed for the purpose of establishing a new healthcare service of in-home hospice in the state of Tennessee.

Service Area: The proposed contiguous Service Area for which CON approval is sought includes ten counties: Bledsoe, Bradley, Hamilton, Marion, McMinn, Meigs, Monroe, Polk, Rhea and Sequatchie Counties. The ten counties have an aggregate quantified underserved need for between 224 and 259 Black hospice patients. It is the Applicant's goal to meet at least half of this underserved need within two years increasing annually thereafter until racial disparities are minimized.

Grundy County will also be served by the Applicant. Grundy County is one of ten distressed counties in Tennessee as it ranks among the top 10 percent of most economically distressed counties in the nation[1]. Given its distressed status, and the fact it has no hospital, Grundy County is exempted from meeting Certificate of Need requirements. With CON approval, the Applicant commits to also being licensed in Grundy County and including it as part of its overall service area. Furthermore, while Grundy County is the only service area county categorized as distressed without a hospital, Bledsoe County is also distressed. Additionally, Meigs, Monroe, Rhea and Sequatchie Counties are categorized as "at-risk" for becoming distressed given their unfavorable economic conditions. Because of Grundy County's exemption from CON, the service area, for CON purposes, is defined as the ten-county contiguous area of Bledsoe, Bradley, Hamilton, Marion, McMinn, Meigs, Monroe, Polk, Rhea and Sequatchie Counties (Service Area).

Existing Similar Service Providers: There are 14 in-home hospice agencies licensed to serve one or more of the ten Service Area counties. The number of in-home hospice agencies licensed to serve each county ranges from 7 providers to 10. Only four of these 14 providers have meaningful market share; in aggregate these four admit 86 percent of the Service Area's hospice patients. The remaining 10 agencies serve between 0 percent and 4 percent of the patients. Despite the number of licensed agencies, there is significant racial disparity evidenced and quantified in the Service Area.

The proposed hospice agency will provide the full complement of hospice services in accordance with the Medicare Conditions of Participation. It will seek to provide the highest standard of care to the residents of the Service Area and will become CHAP accredited as soon as possible after licensure. The Applicant is confident it will successfully serve the underserved hospice patients in this Service Area given its leadership's expertise providing in-home hospice care in other markets across the southeast. As this application will demonstrate, the Applicant has developed a comprehensive community linkage plan, initiated engagement in the Service Area and has garnered appropriate support to enable its approval.

Project Cost: Total project costs are $429,000.

Staffing: The Applicant will employ 12.3 Full-Time Equivalents (FTEs) in Year 1 of which 8.3 will be direct patient care staff. In addition to 12.3 FTEs, Heritage Hospice will have a medical director via contract services. As documented herein, the Applicant will be able to appropriately staff these personnel and provide the services for which CON approval is being sought.

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[1] Tennessee State Government via https://www.tn.gov/transparenttn/state-financial-overview/open-ecd/openecd/tnecd-performance-metrics/openecd-long-term-objectives-quick-stats/distressed-counties.html

2E. Rationale for Approval

A Certificate of Need can only be granted when a project is necessary to provide needed health care in the area to be served, will provide health care that meets appropriate quality standards, and the effects attributed to competition or duplication would be positive for consumers

Provide a brief description not to exceed **ONE PAGE** (for 2E only) of how the project meets the criteria necessary for granting a CON using the data and information points provided in criteria sections that follow.

- Need
- Quality Standards
- Consumer Advantage
  - Choice
  - Improved access/availability to health care service(s)
  - Affordability

Response - ITEM 2E: Rationale for Approval

Need:

Racial disparities for hospice care are evident in the Service Area with as much as a 20 to 25 percent disparity for Blacks receiving hospice services versus the remainder of the population. This disparity is even greater than the overall Tennessee and National disparities. In addition to documenting the racial disparities through quantitative data, qualitative support for racial disparities was provided by healthcare providers throughout the Service Area as well as community organizations and others including the Urban League.

As nurse, hospice administrator and advocate for raising the Black hospice penetration rate, Ms. Hamilton as the CEO of Heritage Hospice will engage the community, healthcare providers and influencers to reduce barriers to access through education, information and guidance, incorporating spiritual and ethical guidelines. This approach will be effective in meeting the mission of Heritage Hospice: To lift up the hospice penetration rate for the Service Area Black population to minimize and/or eliminate racial disparities in end of life hospice care.

Quality Standards:

Heritage Hospice is committed to the appropriate provision of comprehensive, high quality, safe, and cost-effective in-home hospice care to persons who are terminally ill and in need of such services. Heritage Hospice will become CHAP accredited and, therefore, will meet or exceed CHAP Standards of Excellence and demonstrate a commitment to providing quality patient care and services. CHAP accreditation is an independent, not for profit accrediting body for community health programs such as home healthcare agencies and hospice care. CHAP is the leader in improving the quality of community based healthcare services.

Other objective measurements available for quality include the Hospice Quality Reporting Program ("HQRP"), which currently consists of CMS reporting requirements: Hospice Item Set ("HIS"), Hospice Care Index ("HCI") and Hospice Consumer Assessment of Healthcare Providers and Systems ("CAHPS") survey. Heritage Hospice will use this data to benchmark its agency against peers and thereby determine areas where a specific hospice agency needs improvement. The analysis and comparison of this data provides an objective analysis of specific metrics which contribute to overall quality. The positive impact of this methodology will be seen in the quality performance of Heritage Hospice once licensed.

Consumer Advantage – Choice:

Heritage Hospice will provide a new choice for residents in the Service Area, one that has the breadth and depth of understanding the barriers to access identified herein, and educating communities, constituents, organizations and healthcare referral sources to overcome racial disparities that are evident in the Service Area,

Consumer Advantage - Improved Access/availability to care services:

Its community linkage plan demonstrates its plan to effectively and efficiently develop relationships within the region to successfully improve access and availability of in-home hospice services for the terminally-ill population, and in particular the Black population.

Consumer Advantage - Affordability:

The charge structure for in-home hospice services is typically established from Medicare reimbursement based on the designated level of service. Accordingly, most hospices utilize the same pricing and there are not distinguishable differences amongst providers. Proposed charges utilized in the Projected Data Chart are based on Medicare reimbursement and are therefore reasonable in comparison with charges of other hospice agencies in the Service Area, and the remainder of Tennessee. Regarding affordability, the Applicant will admit any hospice eligible patient in the Service Area seeking admission to Heritage Hospice without regard to the person's ability to pay.

3E. Consent Calendar Justification

☐ Consent Calendar Requested (Attach rationale)

If Consent Calendar is requested, please attach the rationale for an expedited review in terms of Need, Quality Standards, and Consumer Advantage as a written communication to the Agency's Executive Director at the time the application is filed.

X Consent Calendar **NOT** Requested

4E. PROJECT COST CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	$0
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$100,000
	3.	Acquisition of Site	$0
	4.	Preparation of Site	$0
	5.	Total Construction Costs	$0
	6.	Contingency Fund	$40,000
	7.	Fixed Equipment (Not included in Construction Contract)	$0
	8.	Moveable Equipment (List all equipment over $50,000 as separate attachments)	$0
	9.	Other (Specify) _Office Furniture	$40,000
		Technology___	$80,000
B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	$0
	2.	Building only	$166,000
	3.	Land only	$0
	4.	Equipment (Specify)____________________	$0
	5.	Other (Specify) ____________________	$0
C.	Financing Costs and Fees:		
	1.	Interim Financing	$0
	2.	Underwriting Costs	$0
	3.	Reserve for One Year's Debt Service	$0
	4.	Other (Specify) ____________________	$0
D.	Estimated Project Cost (A+B+C)		**$426,000**
E.	CON Filing Fee		$3,000
F.	Total Estimated Project Cost (D+E)	**TOTAL**	**$429,000**

RESPONSE:

The Applicant will lease and equip a space for the administrative function of the agency. The lease amount is the appraised value of the building times 5.88 percent (the percent of square foot to total), while the three-year lease has a cost of approximately $129,000. Equipment includes equipment and furnishing for the office and clinical platforms and technology to be used by clinicians to remotely connect to the Heritage Hospice clinical platforms and infrastructure. No one piece of equipment exceeds $50,000.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with TCA §68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, will provide health care that meets appropriate quality standards, and the effect attributed to completion or duplication would be positive for consumers." In making determinations, the Agency uses as guidelines the goals, objectives, criteria, and standards adopted to guide the agency in issuing certificates of need. Until the agency adopts its own criteria and standards by rule, those in the state health plan apply.

Additional criteria for review are prescribed in Chapter 11 of the Agency Rules, Tennessee Rules and Regulations 01730-11.

The following questions are listed according to the three criteria: (1) Need, (2) the effects attributed to competition or duplication would be positive for consumers (Consumer Advantage), and (3) Quality Standards.

NEED

The responses to this section of the application will help determine whether the project will provide needed health care facilities or services in the area to be served.

1N. Provide responses as an attachment to the applicable criteria and standards for the type of institution or service requested. A word version and pdf version for each reviewable type of institution or service are located at the following website. https://www.tn.gov/hsda/hsda-criteria-and-standards.html (Attachment 1N)

RESPONSE:

The *Hospice Services, Certificate of Need Standards and Criteria* and the Applicant's responses to each of the standards and criteria are provided as **Attachment 1N** to this CON application.

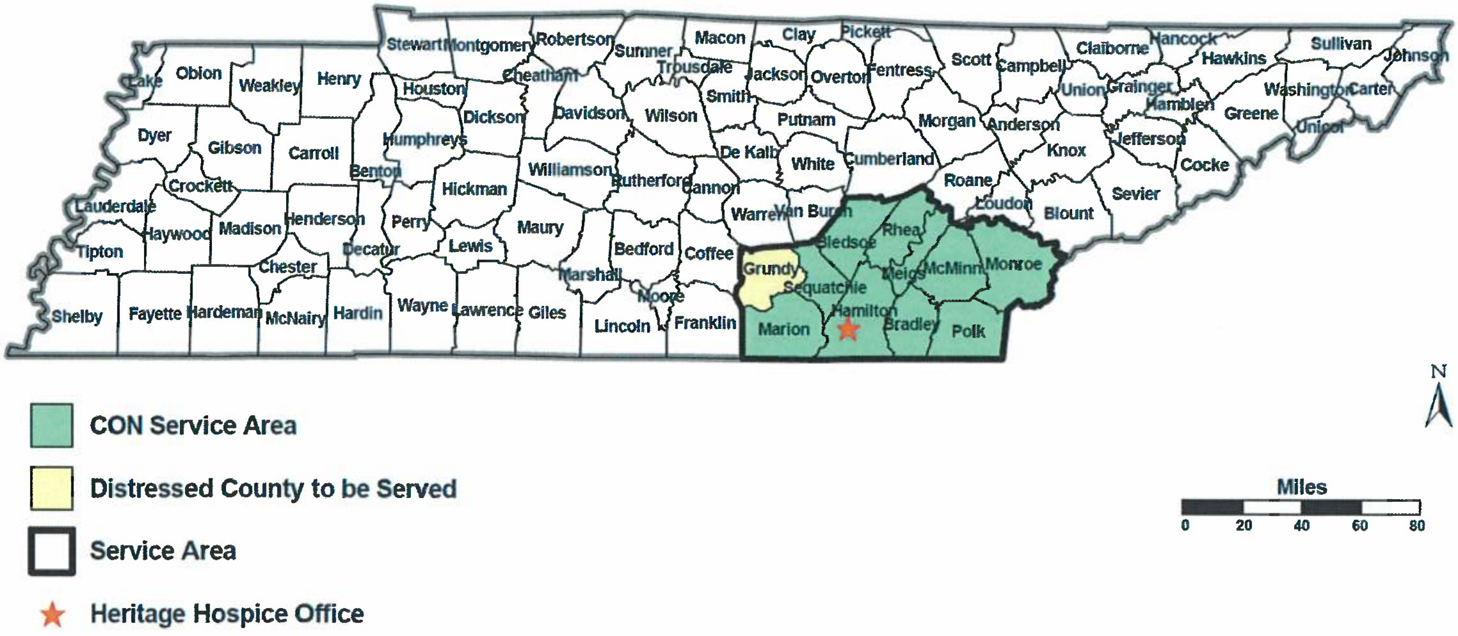
2N. Identify the proposed service area and provide justification for its reasonableness. Submit a county level map for the Tennessee portion and counties boarding the state of the service area using the supplemental map, clearly marked, and shaded to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable. (Attachment 2N)

RESPONSE:

The defined service area for which CON approval is being sought includes a contiguous ten county region in southeast Tennessee extending from Marion and Sequatchie Counties on the west to Polk and Monroe Counties on the east. The Applicant's office will be located in Chattanooga, Tennessee within Hamilton County, central on an east-west plane to the ten service area counties. The ten-county contiguous area includes Bledsoe, Bradley, Hamilton, Marion, McMinn, Meigs, Monroe, Polk, Rhea and Sequatchie Counties ("Service Area").

In addition to the Service Area, the Applicant will seek licensure in contiguous Grundy County which is north of Marion and west of Sequatchie Counties. Given Grundy County's distressed status, it is exempt from this CON application. However, the Applicant commits to including it and serving this distressed community as part of its licensure application.[2]

The Service Area is reasonable and justified as the counties are contiguous, and each demonstrates a racial disparity in serving the Black population at the end of life with in-home hospice services as detailed in this CON Application. A map of the service area's geographic position relative to the entire state is illustrated below.



Heritage Hospice and Palliative Care
Project Service Area

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[2] Because approval of Grundy County is not being sought via this CON application, all data herein – including historical utilization, projected demand, forecasted utilization, forecasted revenues and proposed staffing -- exclude Grundy County.

The below map enlarges the above Service Area to better illustrate the location of each of the ten Service Area counties relative to one another. Hamilton and Bradley Counties are central to the Service Area along the Tennessee – Georgia/Alabama state lines. These are the two most populated counties in the Service Area. Hamilton County, with Chattanooga as its county seat, has 53 percent of total Service Area population and 84 percent of Service Area Black population. Bradley County, with Cleveland as its county seat, has 16 percent of total Service Area population and 7 percent of Service Area Black population.

Marion County to the west of Hamilton County also shares the Tennessee – Alabama border, while Polk County to the east of Bradley County shares the Tennessee – Georgia border. The eastern counties in the Service Area (Polk and Monroe) share the Tennessee – North Carolina state border. The remaining five counties (Sequatchie, Bledsoe, Rhea, Meigs and McMinn) are rural, located to the north of Bradley and Hamilton Counties and accessible from these more populated counties. The map below provides a closer illustration of the counties in the Service Area.

As noted, Grundy County will also be served by the Applicant. Grundy County is one of ten distressed counties in Tennessee as it ranks among the top 10 percent of most economically distressed counties in the nation[3]. Given its distressed status, and the fact it has no hospital, Grundy County is exempted from meeting Certificate of Need requirements. With CON approval, the Applicant commits to also being licensed in Grundy County and including it as part of its overall service area. Furthermore, while Grundy County is the only service area county categorized as distressed without a hospital, Bledsoe County is also distressed. Additionally, Meigs, Monroe, Rhea and Sequatchie Counties are categorized as "at-risk" for becoming distressed given their unfavorable economic conditions.

Although the Service Area counties are contiguous to adjacent states, the Applicant does not plan on serving patients in these other states but rather just serving patients within the defined service area. As discussed throughout this CON Application, the Applicant is well qualified to license and implement an in-home hospice service to meet the identified underserved needs of this Service Area.

3N. **A.** Describe the demographics of the population to be served by the proposal.

B. Provide the following data for each county in the service area:

- Using current and projected population data from the Department of Health. (www.tn.gov/health/health-program-areas/statistics/health-data/population.html);
- the most recent enrollee data from the Division of TennCare (https://www.tn.gov/tenncare/information-statistics/enrollment-data.html),
- and US Census Bureau demographic information (https://www.census.gov/quickfacts/fact/table/US/PST045219).
  Be sure to identify the target population, e.g. Age 65+, the current year and projected year being used.

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[3] Tennessee State Government via https://www.tn.gov/transparenttn/state-financial-overview/open-ecd/openecd/tnecd-performance-metrics/openecd-long-term-objectives-quick-stats/distressed-counties.html

RESPONSE:

The Service Area is home to 719,374 residents and is expected to grow by 2.5 percent in the next four years, incurring 17,804 new residents by 2027. Of the ten counties in the Service Area, Hamilton is the most populated with more than 380,000 residents currently and anticipated to incur 10,418 additional people in the ensuing four years, to reach 390,799 total residents by 2027. Bradley County is the second most populous at 111,877 people and slated to increase to 115,338 people by 2027. Nine of the ten counties show four-year growth between 1.6 and 3.4 percent; only Marion County shows an overall decrease in population during this four-year period.

In terms of the 65 and older population, by 2027 it will represent 21.4 percent of total population. The forecasted growth in the elderly is 8.7 percent, a rate about 3.5 times the overall population increase. Elderly growth by county ranges between 6.0 and 10.5 percent. In terms of population count, the 65 and older population is currently 145,220 and forecasted to increase by 12,636 to 157,856 in 2027. This increase represents 71 percent of the total forecasted increase in the Service Area. And in half of the counties, the increase in the senior population exceeds the overall population increase meaning that the population under age 65 is decreasing while the 65 and older increases. It is this senior cohort who are the most frequent utilizers of hospice care services and is therefore in general, the target population.

In terms of absolute growth, Hamilton County's senior population will increase by nearly 6,000 persons, almost half of the Service Area growth. Bradley County is forecasted to increase by 2,149, the second highest. Monroe and McMinn Counties' increase during the next four years follow at 1,120 and 1,023, respectively. Population statistics from the Tennessee Department of Health are supplied on the table on the following page.

The median age in the Service Area exceeds the State (39.2) with each county's median age ranging between a low of 39.4 to a high of 46.1. Per the Census Bureau, median household income in the Service Area ranges from $47,835 in Sequatchie County to $61,050 in Hamilton County. With the exception of Hamilton County, median household income in all other nine counties is less than the State's median of $58,516.

Further, 13.4 percent of Service Area residents fall below the poverty level which approximates Tennessee's rate of 13.6 percent below poverty level. Seven of the ten counties have poverty level at or above the State, with a high in Bledsoe County of 22.1 percent.

In terms of TennCare enrollees, there are 176,072 in the Service Area which equates to 24.5 percent of the population. This nears the Tennessee computed rate of 25.1 percent of population as TennCare enrollees.

The above information for the total population and the target population (65+) is presented in the table on the following page.

Demographic Variable/ Geographic Area	Department of Health/Health Statistics							Census Bureau				TennCare	
	Total Population-Current Year 2023	Total Population-Projected Year 2027	Total Population-% Change	*Target Population – Ages 65+ Current Year 2023	Target Population-Ages 65+ Project Year 2027	Target Population-Ages 65+ % Change, '23-'27	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total
Bledsoe County	15,573	15,958	2.5%	3,185	3,521	10.5%	22.1%	43.8	$51,884	3,442	22.1%	3,857	24.8%
Bradley County	111,877	115,338	3.1%	21,166	23,315	10.2%	20.2%	39.6	$55,426	13,090	11.7%	28,387	25.4%
Hamilton County	380,381	390,799	2.7%	73,546	79,524	8.1%	20.3%	39.4	$61,050	47,928	12.6%	81,800	21.5%
Marion County	28,904	28,793	(0.4 %)	6,407	6,793	6.0%	23.6%	43.4	$53,148	4,682	16.2%	8,115	28.1%
McMinn County	54,986	55,847	1.6%	12,074	13,097	8.5%	23.5%	42.1	$51,253	7,973	14.5%	15,960	29.0%
Meigs County	12,753	13,005	2.0%	2,873	3,157	9.9%	24.3%	45.6	$54,420	1,938	15.2%	3,982	31.2%
Monroe County	48,151	49,178	2.1%	11,385	12,505	9.8%	25.4%	44.2	$48,488	7,512	15.6%	13,867	28.8%
Polk County	17,083	17,354	1.6%	3,890	4,255	9.4%	24.5%	46.1	$49,446	2,306	13.5%	4,722	27.6%
Rhea County	34,052	34,768	2.1%	7,042	7,658	8.7%	22.0%	40.3	$48,872	5,380	15.8%	10,696	31.4%
Sequatchie County	15,614	16,138	3.4%	3,652	4,031	10.4%	25.0%	44.6	$47,835	2,124	13.6%	4,686	30.0%
SERVICE AREA	**719,374**	**737,178**	**2.5%**	**145,220**	**157,856**	**8.7%**	**21.4%**			**96,375**	**13.4%**	**176,072**	**24.5%**
State of TN	7,071,060	7,282,134	3.0%	1,290,989	1,413,040	9.5%	19.4%	39.2	$58,516	931,994	13.6%	1,774,749	25.0%

Source: Tennessee Department of Health, Census.gov Quick Facts June 2023 and ACS survey for median age by county and state, Persons Below Poverty Level is Census.gov poverty percent times Total Population 2023, and Division TennCare, Enrollment as of April 2023 (latest available). TennCare Enrollees as % of Total is TennCare Enrollees (April 2023) divided by Total Population 2023.

Target Population is the 65 and older population.

Black Demographics

Heritage Hospice was formed with the purpose of meeting the end of life hospice needs for the underserved Black population throughout the Service Area. There have been several studies that have examined racial disparities in hospice utilization and have found that Black individuals are less likely to utilize hospice care compared to those who are not Black. Analysis of utilization in the Service Area confirms the disparity between Black and others' utilization of hospice services exists locally throughout the Service Area. The disparity is discussed in response to **Question 4N** and elsewhere in this CON Application.

In terms of demographics of the Black population throughout the Service Area, there are approximately 74,000 Black persons residing in the ten-county Service Area. This represents between 10 and 10.5 percent of the total population, ranging from a low in Sequatchie County of 0.4 percent to a high in Hamilton County of 16.9 percent. With more than 80 percent of the Service Area's Black population residing in Hamilton County, it is a compelling reason for Heritage Hospice to establish its office within this Service Area County.

The following tables provide 2023 and 2028 total[4] and Black population estimates and forecasts as provided by Claritas Spotlight.

2023 Population Estimate and 2028 Population Forecast
Total Population and Black Population by Service Area County

	Population Estimate 2023			Population Forecast 2028			% Increase	
County	Total	Black	% Black	Total	Black	% Black	Black	Total
Bledsoe	15,521	834	5.4%	16,461	913	5.5%	9.5%	6.1%
Bradley	111,462	5,385	4.8%	116,377	5,641	4.8%	4.8%	4.4%
Hamilton	372,901	63,103	16.9%	386,771	61,485	15.9%	-2.6%	3.7%
McMinn	54,185	1,839	3.4%	55,635	1,789	3.2%	-2.7%	2.7%
Marion	28,915	1,529	5.3%	29,384	2,304	7.8%	50.7%	1.6%
Meigs	13,193	196	1.5%	13,822	301	2.2%	53.6%	4.8%
Monroe	46,909	773	1.6%	48,199	825	1.7%	6.7%	2.8%
Polk	17,870	94	0.5%	18,429	147	0.8%	56.4%	3.1%
Rhea	33,251	583	1.8%	34,080	554	1.6%	-5.0%	2.5%
Sequatchie	16,659	70	0.4%	17,732	64	0.4%	-8.6%	6.4%
Service Area	710,866	74,406	10.5%	736,890	74,023	10.0%	-0.5%	3.7%

Source: Claritas Spotlight 2023

As observed in the above table, Hamilton County has the majority of the Black population in both 2023 and 2028, despite expecting a decrease during the next five years. In contrast, three counties' Black population is expected to increase by more than 50 percent with three other counties increasing between 4.8 and 9.5 percent. Overall, the Service Area Black population is fairly constant during the next five years, although there is a redistribution from Hamilton County to several of the surrounding counties.

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[4] Claritas Spotlight population estimates in 2023 differ slightly from the State of Tennessee population estimates. The Claritas 2023 estimates are included herein to enable computing the proportion of Black population in each county and the overall Service Area from the same source.

With respect to the Black population that is 65 years of age and older, it is expected to increase 13 percent between 2023 and 2028 in contrast with the overall Black population decreasing slightly. And while six of the ten counties show an increase above, nine of the ten counties' Black population is expected to increase during the next five years, with the tenth county remaining constant. This information is presented in the following table.

2023 and 2028 Black Population, Age 65 and Older by Service Area County

	Black Population 65+		
County	**2023**	**2028**	**% Change**
Bledsoe	11	13	18.2%
Bradley	585	706	20.7%
Hamilton	8,443	9,320	10.4%
McMinn	295	311	5.4%
Marion	318	532	67.3%
Meigs	40	66	65.0%
Monroe	143	170	18.9%
Polk	19	35	84.2%
Rhea	104	110	5.8%
Sequatchie	4	4	0.0%
Service Area	9,962	11,267	13.1%

Source: Claritas Spotlight 2023.

Overall, the percentage of Black population which are elderly is 13.4 percent, ranging from a low of 1.3 percent in Bledsoe County to near 21 percent in Marion County. Hamilton County, with more than 80 percent of the Black population is at the average, 13.4 percent of Black population is elderly. The residency of the Black population by County provides additional support for Heritage Hospice locating its office within Hamilton County. Documented racial disparities relative to hospice utilization by the Black population is discussed next.

4N. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly those who are uninsured or underinsured, the elderly, women, racial and ethnic minorities, TennCare or Medicaid recipients, and low income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

RESPONSE:

Demonstrated Racial Disparities in Hospice Care

Hospice offers patients compassionate care that is focused on pain relief and symptom management so the patient can die a good death, with dignity. In the United States, hospice is considered the gold standard for care of terminally ill patients. Yet, racial and ethnic minorities are underrepresented among those who receive this type of care. There is a well-documented significant disparity in access to hospice services amongst major minority groups including Hispanics and Blacks when compared to all others. Although hospice use is increasing and patients in the United States are increasingly dying at home, racial and ethnic disparities in treatment intensity at the end of life, including hospice, remain.[5]

The proposed Service Area is no exception; it too exhibits similar racial disparities. Important racial and ethnic differences in terminal illness result from acknowledgement, religiousness, and treatment preferences among patients with advanced care. A study conducted by Alexander K. Smith titled Racial and Ethnic Differences in Advance Care Planning Among Patients with Cancer: Impact of Terminal Illness Acknowledgement, Religiousness, and Treatment Preferences, found that Black patients were nearly half and Hispanic patients were two times more likely than white patients to prefer life-prolonging care. Furthermore, compared with white patients, Black and Hispanic patients were 40 percent less likely to have an advance care plan. Advance care planning is the process by which patients, with their physicians and loved ones, establish care plans which includes end of life care.

A 2017 RAND study found that of those Black and Hispanic patients who obtain hospice care, they are more likely than white patients to receive care from lower quality hospices, which is consistent with other research that has found that minority patients tend to receive care from lower-quality physician practices and hospitals.[6] However, studies also show that within quality hospices, the minority patients once admitted receive similar quality hospice services as non-minorities.

The 2020 study published by Katherine Ornstein et al, concludes that Black decedents undergo more intensive treatments at the end of life and are less likely to use hospice services relative to white decedents. More sustained efforts must be made to reduce disparities in end-of-life care through better education and training of healthcare professionals to promote the discussion of personal values and preferences for the end of life in Black communities.[7]

According to a plethora of research, Blacks tend to have less access to palliative care and tend not to choose hospice when they are terminally ill. They are the most likely cohort to choose life support over palliative care and hospice, and they are the most likely group to die in the hospital.[8] There have been several other studies that have examined racial disparities in hospice utilization and have found that Black individuals are less likely to utilize hospice care compared to white individuals. Below are some examples of such studies:

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[5] Ornstein KA, Roth DL, Huang J, Levitan EB, Rhodes JD, Fabius CD, Safford MM, Sheehan OC. Evaluation of Racial Disparities in Hospice Use and End-of-Life Treatment Intensity in the REGARDS Cohort. JAMA Netw Open. 2020 Aug 3;3(8):e2014639. doi: 10.1001/jamanetworkopen.2020.14639. PMID: 32833020; PMCID: PMC7445597.

[6] Price, Rebecca Anhang, Black and Hispanic Patients More Likely to Use Lower-Quality Hospices, July 5, 2017

[7] Ornstein KA, Roth DL, Huang J, Levitan EB, Rhodes JD, Fabius CD, Safford MM, Sheehan OC. Evaluation of Racial Disparities in Hospice Use and End-of-Life Treatment Intensity in the REGARDS Cohort. JAMA Netw Open. 2020 Aug 3;3(8):e2014639. doi: 10.1001/jamanetworkopen.2020.14639. PMID: 32833020; PMCID: PMC7445597.

[8] Adrien, Christopher, 5 Reasons Why African Americans Are Less Likely to Choose Hospice, May 12, 2017

1. A 2018 Study in SSM – Population Health entitled Racial and Ethnic Differences in End of Life Care in the United States, Evidence from the Health and Retirement Study (HRS) revealed significant disparities in end of life care utilization and end of life planning in the United States.

2. Researchers at John Hopkins Medicine and three collaborating institutions report that Black patients voluntarily seek substantially more intensive treatment, such as mechanical ventilation, gastronomy tube insertion, hemodialysis, CPR and multiple emergency room visits in the last six months of life, while white patients more often choose hospice services (August 2020).

3. Published in 2022, the study "Racial and Ethnic Differences in Hospice Use and Hospitalizations at End of Life Among Medicare Beneficiaries with Dementia" found that non-Hispanic Black and Hispanic decedents with dementia used less hospice but more emergency department and inpatient services, and incurred roughly 60 percent higher Medicare inpatient expenditures at the end of life compared with non-Hispanic white decedents. And the proportion of dementia beneficiaries completing advanced care planning was significantly lower amount these minorities.

4. A study published in the Journal of Palliative Medicine in 2017 analyzed data from the National Health and Aging Trends Study (NHATS) and found that Black individuals had lower rates of hospice utilization compared to White individuals. The study suggested that racial disparities in hospice use could be attributed to factors such as lower awareness, cultural beliefs, and mistrust.

5. Another study published in the Journal of Pain and Symptom Management in 2018 examined racial disparities in hospice utilization among patients with heart failure. The study, based on data from the OPTIMIZE-HF registry, found that Black patients with heart failure were less likely to utilize hospice services compared to White patients. The authors suggested that differences in access, knowledge, and preferences could contribute to these disparities.

6. A study published in Health Affairs in 2020 analyzed Medicare claims data and found that Black patients had significantly lower hospice utilization rates compared to White patients. The study also highlighted geographic variations in hospice utilization and suggested that systemic factors, such as healthcare provider characteristics and availability of services, could contribute to these disparities.

7. A New York Times article titled, A Racial Gap in Attitudes Toward Hospice Care, states that this deep-seated suspicion is an attitude borne out of recent federal statistics showing that nearly half of white Medicare beneficiaries enrolled in hospice before death, compared to only a third of Black enrollees. The racial divide is even more significant when it comes to advance care directives which is meant to help families make life or death decisions reflective of the patient's choice. The article cites some 40 percent of whites age 70 and older have such plans compared to only 16 percent of Blacks. Researchers conclude that this misconception is the result of deeply rooted toxic distrust of a healthcare system that was once segregated. For some of this demographic, they have had a lifetime of difficulty getting access to care as a result of poverty, lack of health insurance, or difficulty finding a medical provider. Then you have a physician who tells them they want to transition their loved one to hospice care. There is a great deal of skepticism, particularly because Medicare requires the patient terminate treatment to qualify for hospice.

Additional research which has been conducted for this proposed project explored potential reasons why Black patients are less likely to use hospice. Some research suggests that Black patients are more likely to want aggressive end-of-life treatment. A 2017 Kaiser Family Foundation and Economist survey found that while few Americans viewed living as long as possible as "extremely important," the share of Black respondents who felt this way (45%) was higher than that of white respondents (18%) (Hamel et al., 2017). Another survey of Black American older adults in North Carolina found they were less likely to prefer or request hospice support than their white counterparts (Cagle et al., 2016). Black decision makers for dementia patients elected life sustaining treatments more than comfort-focused care (Hart et al., 2022). Additionally, advance directives increase the odds of a discharge to hospice, and Black patients are less likely to complete advance directives (Haines et al., 2021). One expert noted that in her Black American community, there may be more collective decision-making preferences. She described her mother not understanding why she would need a written advanced directive if her daughter was there to advocate on her behalf.[9]

Other research suggests the Black patients may be unaware of hospice care and its benefits. Black decision makers for dementia patients often did not use hospice fully due to a lack of information and preparedness (Hart et al., 2022), and a California-based study found Black people were less likely than non-Hispanic white peoples to be aware of hospice (Bazargan et al., 2021). Qualitative research among Black church members indicated that lack of knowledge of hospice services and spiritual beliefs were the top two contributing factors to underutilization of hospice care (Townsend et al., 2017). Further, additional interviews with Black church leaders found their congregants were unfamiliar with the terms "hospice" and "palliative care," while also harboring beliefs, perceptions, and feelings about death and dying that they had not communicated to their family members or providers.[10]

In evaluating the various studies to understand the underlying reasons why Blacks are less likely to choose hospice, there are five primary reasons identified. They are as follows:

1. *A deeply rooted distrust of the healthcare system.* This is due to a history of disrespectful and inadequate treatment by the (predominantly white) medical community. This history makes for a fraught relationship between Black communities and the medical communities that serve them, with hospice included. This paired with the hospice stigma as a "place to go die", it is apparent that Blacks have an incentive not to choose hospice.

2. *Lower economic status and resources.* The unfortunate truth is that America's race relations have left many Black communities at an economic disadvantage. When it comes to healthcare, hospice and palliative care included, lower economic status and resources have a definite effect on the breadth and scope available to them. Poorer communities tend to have less access to healthcare services.

3. *A greater willingness to spend their resources to stay alive.* A recent study found that 8 out of 10 Black are willing to spend everything they had to stay alive, compared with only half of the white counterpart. This trend may be positively correlated with cultural differences, as well as socioeconomic disparities.

4. *Lower care satisfaction among family members.* Studies have shown that hospice and palliative care help improve satisfaction in end-of-life care. For Blacks, this is not the case. Family members of these patients consistently reported lower satisfaction in end-of-life care. The most widely reported discontent was absent or problematic communication with physicians and a higher tendency for patients to not have written advance care planning documents. Lower satisfaction in care means palliative care and hospice are earning a poor reputation in Black communities the more word spreads throughout communities.

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[9] 2022 Hospice Information Gathering Report, Health Equity in the Hospice Setting, Submitted to Centers for Medicare & Medicaid Services by Abt Associates, December 16, 2022.

[10] Ibid

5. *End of life care is in disarray.* End of life care is inconsistently offered throughout the nation. Quality of care in hospice programs can vary state to state, from city to city and even from program to program. A national survey recently revealed that across the country, end of life care programs did not meet the national staffing recommendations which often results in such services being generally unavailable. Unavailability of services or timeliness of service further compounds the issue of racial disparity in end-of-life care.

Additional research to the above that has been evaluated and incorporated into its Community Linkage Plan is the development of a culturally sensitive intervention to promote awareness of advance care planning, palliative care and hospice.[11] Through study of the perceptions, barriers and conflicting attitudes, Heritage Hospice will develop a comprehensive approach to address and mitigate these disparities.

On a national basis, annually Medicare publishes data identifying what percent of Medicare beneficiaries who died during the study year used hospice. In the most recent Medicare Payment Policy (MedPac) Report to Congress, Table 10-3, page 293 included the following percent of Medicare decedents who used hospice services during 2021. 2010 is also shown to demonstrate the change during the past decade.

Race/Ethnicity	2010	2021	Change
All Decedents	43.8%	47.3%	3.5%
White	45.5%	50.0%	4.5%
Black	34.2%	35.6%	1.4%
Hispanic	36.7%	34.3%	-2.4%
Asian American	30.0%	36.3%	6.3%
North American Native	31.0%	33.8%	2.8%
Black Differential to All	9.6%	11.7%	2.1%
Black Differential to White	11.3%	14.4%	3.1%

Source: MedPac Report to Congress, March 2023, Table 10-3

As shown in the above table, the disparity between Blacks and "All" and Blacks and Whites continues to widen. In 2010, Blacks used hospice 11.3 percent less than Whites. In 2021, this differential increased by 3.1 percent to 14.4 percent. Similarly, the disparity between Blacks and All increased from 9.6 to 11.7 percent during this period. The conclusion is that not only has there been decades long disparity, but it is also increasing over time.

The Service Area exhibits even greater disparities. The detailed Medicare database which provides information about Medicare beneficiaries and the use of hospice was accessed to obtain hospice utilization by race and ethnicity for each Service Area County in 2021 (the same source as the national information presented above). This was then compared to the Medicare decedents during the same time period to conclude on the hospice penetration at the county level to ascertain the disparity between Blacks, Whites and All. Unfortunately, only Bradley and Hamilton Counties had sufficient Black hospice admissions to not require 'suppression' of the actual number of Black hospice admissions. Notably, while those two counties account for 68 percent of the total population within the Service Area, they account for 92 percent of the Service Area's Black population. Those two counties 2021 information is presented in the following table with the State of Tennessee overall data presented for comparison purposes.

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[11] The Desires of Their Hearts: The Multidisciplinary Perspectives of African Americans on End-of-Life Care in the African American Community, American Journal of Hospice and Palliative Care, July 2017, Rhodes et al.

County/State	All	White	Black	Black vs All Disparity	Black vs White Disparity
Bradley	60.9%	62.1%	35.7%	25.2%	26.4%
Hamilton	67.0%	70.9%	48.9%	18.1%	22.0%
Tennessee	49.4%	51.4%	36.6%	12.8%	14.8%

Source: Data Analytics, Medicare data base, CY 2021

The disparity between Blacks and Whites/All is notable with Bradley County having a 25 to 26 percent disparity and Hamilton County having an 18 to 22 percent disparity. This compares with Tennessee overall of 12.8 to 14.8 percent. In calendar year 2021, according to Tennessee Department of Health (TDOH) Death Statistics, there were 936 Black deaths in Bradley and Hamilton combined.[12] If these two counties had achieved the same hospice penetration rate for Blacks as for their white counterparts, there would have been 209 more hospice admissions in these two counties.

The same TDOH death statistics data file identifies 1,007 Black deaths in six counties; the other four counties' Black death data is suppressed based on TDOH policy. Therefore, total Black deaths in the ten-county Service Area could be as high as 1,047 (if there were ten such deaths per county in the four missing counties). Ranging between 1,011 (one per missing county) and 1,047 (ten per missing county), the 209 referenced above extrapolated to the ten counties results in between 225 and 233 additional hospice admissions in the ten county Service Area if disparities were to be eliminated.

Another resource to evaluate penetration rates in a given Service Area within Tennessee is to access each hospice's Joint Annual Report to ascertain the number of hospice admissions by race within each county. This is a unique resource as it includes all payors/patients not just Medicare payors/patients. Such data is currently available through fiscal year 2022. However, Tennessee death statistics by race are only available through calendar year 2021 and as noted above, four of the counties in the Service Area have Black deaths suppressed during this time period. Following are total deaths and Black deaths for the three most recent period available (2019 through 2021) for the Service Area. The highlighted counties are the only ones for which Black deaths are publicly available for the period.

County	Total Deaths			Black Deaths			Blacks as a % of Deaths		
	2019	2020	2021	2019	2020	2021	2019	2020	2021
Bledsoe	157	175	185	n/a	n/a	n/a	n/a	n/a	n/a
Bradley	1,163	1,396	1,612	46	49	67	4.0%	3.5%	4.2%
Hamilton	3,840	4,240	4,568	723	807	869	18.8%	19.0%	19.0%
McMinn	730	857	953	24	33	39	3.3%	3.9%	4.1%
Marion	350	425	478	17	14	14	4.9%	3.3%	2.9%
Meigs	196	192	214	n/a	n/a	n/a	n/a	n/a	n/a
Monroe	649	720	827	11	12	18	1.7%	1.7%	2.2%
Polk	249	276	351	n/a	n/a	n/a	n/a	n/a	n/a
Rhea	416	503	559	n/a	12	n/a	n/a	2.4%	n/a
Sequatchie	170	188	230	0	0	0	0.0%	0.0%	0.0%
Service Area	7,920	8,972	9,977	821	927	1,007	10.4%	10.3%	10.1%
Counties with Entries	*7,318*	*8,329*	*9,227*	*821*	*927*	*1,007*	11.2%	11.1%	10.9%

Source: Tennessee Death Statistical File, 2019 through 2021, Tennessee Department of Health, Division of Vital Records and Statistics. Counties with Entries indicate those which have reported Black deaths.

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[12] *Tennessee Death Statistical File, 2021, Tennessee Department of Health, Division of Vital Records and Statistics. Rates Calculated Based on Total Population Counts from The Tennessee Population Estimates Program, 2021, Tennessee Department of Health, Division of Population Health Assessment.*

As noted in **Question 3N**, the Service Area is home to 719,000 individuals with approximately 74,000 of them Black, 10.5 percent of total. Based on the above table, Black deaths are at a higher rate than the rest as they represent approximately 11 percent of deaths with a lower percent of population.

The following table presents total hospice admissions by county by reported year, black admissions by county by reported year and the resulting percentage of Black admissions to total. The six counties with reported deaths are highlighted in yellow with a corresponding subtotal presented at the bottom of the table.

County	Hospice Admissions			Black Hospice Admissions			Blacks as a % of Hospice Admissions		
	2020	2021	2022	2020	2021	2022	2020	2021	2022
Bledsoe	294	90	95	5	0	2	1.7%	0.0%	2.1%
Bradley	703	890	1,011	15	28	36	2.1%	3.1%	3.6%
Hamilton	3,356	3,962	3,524	387	389	364	11.5%	9.8%	10.3%
McMinn	524	552	586	13	14	31	2.5%	2.5%	5.3%
Marion	221	265	329	13	10	14	5.9%	3.8%	4.3%
Meigs	159	137	153	4	6	5	2.5%	4.4%	3.3%
Monroe	349	331	373	7	5	21	2.0%	1.5%	5.6%
Polk	184	167	181	2	8	14	1.1%	4.8%	7.7%
Rhea	351	364	457	3	3	22	0.9%	0.8%	4.8%
Sequatchie	283	138	221	1	0	4	0.4%	0.0%	1.8%
Service Area	6,424	6,896	6,930	450	463	513	7.0%	6.7%	7.4%
Counties with Entries	*5,436*	*6,138*	*6,044*	*436*	*446*	*470*	*8.0%*	*7.3%*	*7.8%*

Source: Joint Annual Report, Master File, 2020 through 2022. Counties with Entries indicate those which have reported Black deaths.

On its surface the above data demonstrates a disparity for Black hospice admissions. By year, the percent Black admissions total between 6.7 and 7.4 percent of hospice admissions when they represent approximately 11 percent of deaths. This is approximately two-thirds of the expected or a proportion rate (7%/11%). On a county-by-county comparison for the most recent year of reported deaths (2021), following are the comparative percent of deaths versus percent of hospice admissions from the above tables.

County	2021 Black as a	
	% of Deaths	% of Hospice Admits
Bledsoe	n/a	0.0%
Bradley	4.2%	3.1%
Hamilton	19.0%	9.8%
McMinn	4.1%	2.5%
Marion	2.9%	3.8%
Meigs	n/a	4.4%
Monroe	2.2%	1.5%
Polk	n/a	4.8%
Rhea	n/a	0.8%
Sequatchie	0.0%	0.0%
Service Area	10.1%	6.7%
Counties with Entries	*10.9%*	*7.3%*

Given that some death data is available (six counties) for 2020 and 2021, the hospice penetration rate for Blacks may be computed during these years. This may be compared to total or overall hospice penetration rate as well as the penetration rate for non-Blacks. The analysis for both 2020 and 2021 further demonstrates the disparity in hospice utilization throughout the Service Area, presented in the below table.

	Black vs All Disparity		**Black vs Non-Black Disparity**	
County	**2020**	**2021**	**2020**	**2021**
Bledsoe	n/a	n/a	n/a	n/a
Bradley	19.7%	13.4%	20.5%	14.0%
Hamilton	31.2%	42.0%	38.5%	51.8%
McMinn	21.7%	22.0%	22.6%	23.0%
Marion	-40.9%	-16.0%	-42.2%	-16.5%
Meigs	n/a	n/a	n/a	n/a
Monroe	-9.9%	12.2%	-10.0%	12.5%
Polk	n/a	n/a	n/a	n/a
Rhea	n/a	n/a	n/a	n/a
Sequatchie	--	--	--	--
Service Area	23.1%	23.1%	25.7%	25.7%
Counties with Entries	18.2%	22.2%	20.5%	25.0%

Applying the most recent disparity for Black versus "All" to Black deaths in the Service Area results in a computed underservice to the Black population of 224 to 233 admissions.[13] Applying the Black versus "Non-Black" disparity results in a shortfall of 251 to 259 underserved population throughout the Service Area.[14]

Economic Status of the Service Area

There are 176,072 TennCare enrollees in the Service Area which equates to 24.5 percent of the population. This nears the Tennessee computed rate of 25.1 percent of population as TennCare enrollees. Per the Census Bureau, median household income in the Service Area ranges from $47,835 in Sequatchie County to $61,050 in Hamilton County. With the exception of Hamilton County, median household income in all other nine counties is less than the State's median of $58,516. Further, 13.4 percent of Service Area residents fall below the poverty level which approximates Tennessee's rate of 13.6 percent below poverty level. Seven of the ten counties have poverty level at or above the State, with a high in Bledsoe County of 22.1 percent.

Contiguous to the Service Area counties, and also with an underserved hospice population, is Grundy County. The Applicant commits to seeking licensure in this county; it is not the subject of this CON application solely by virtue of the fact that Grundy County is designated as an economically distressed county without a hospital. Grundy County's less desirable economic metrics indicate 20.5 percent of its population live below the poverty level and its median household income is only $45,150 (lower than each of the Service Area counties). Nearly 39 percent of its population is enrolled in TennCare (5,174 persons). The Applicant will seek to equally serve Grundy County along with the ten counties for which it is seeking CON approval.

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[13] Computed at 22.2% x 1,007 to 23.1% x 1,007, recognizing the 1,007 only accounts for 6 counties, with up to 40 additional deaths not included in this computation.

[14] Computed at 25.0% x 1,007 to 25.7% x 1,007, recognizing the 1,007 only accounts for 6 counties, with up to 40 additional deaths not included in this computation.

While Grundy County is the only service area county categorized as distressed without a hospital, Bledsoe County is also distressed. Additionally, Meigs, Monroe, Rhea and Sequatchie Counties are categorized as "at-risk" for becoming distressed given their unfavorable economic conditions. Heritage Hospice is fully committed to serving the special needs of the entire service area, including Grundy County via licensure (not via Certificate of Need process). The lack of access resulting in lower utilization of hospice services in the entire Service Area, and specifically as it relates to the Black population was discussed above.

Heritage Hospice Plan to Serve the Underserved

Operationally, Heritage Hospice will develop a set of tools and practices to address the cultural, health systems and other impediments to hospice care that confront the underserved population. It will create culturally sensitive interventions to promote awareness of advance care planning, palliative care and hospice care. It will formulate mechanisms that focus on building trust in the Black cohort and partner with existing community resources that service the Black community such as the Urban League, churches and community centers. These mechanisms will deal with specific concrete obstacles long identified by health policy makers and researchers but are frequently not well addressed.

Heritage Hospice will employ active members of the local Black community to ensure it remains engrained and attuned to the entire end of life needs of this demographic to ameliorate the misconceptions of hospice care and ensure each resident has equal access to the hospice benefit. Heritage Hospice will also carry out an array of regularly scheduled community education events and take every opportunity to educate those who may have a deep-rooted mistrust of healthcare, and of hospice. Its hospice service platform will be a focused minority outreach program in conjunction with assembling an appropriate care team for assessment and treatment of the underserved Black Service Area population.

Heritage Hospice's Community Linkage Plan objectives and strategies are provided in response to **Question 1N, Criterion #2** within **Attachment 1N**. Please refer to **Attachment 4N** for articles and studies referenced above.

5N. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days. Average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g. cases, procedures, visits, admissions, etc. **This does not apply to projects that are solely relocating a service.**

RESPONSE:

There are 14 hospice agencies licensed to serve one or more of the Service Area counties. The number of hospice agencies licensed to serve each county ranges from seven to ten providers. The agencies along with their State ID, the counties in which they are licensed to serve and the total agencies by county are presented in the following table.

Licensed Hospice Agencies by Service Area County
Calendar Year 2022

State ID	Hospice Agency	Bledsoe	Bradley	Hamilton	Marion	McMinn	Meigs	Monroe	Polk	Rhea	Sequatchie	Total
05602	Blount Memorial Hospital Hospice							X				X
06063 & 06613	Adoration Home Health & Hospice Care East TN	X	X	X	X	X	X	X	X	X	X	X
06603	Kindred Hospice		X	X		X	X		X			X
19694	Avalon Hospice	X	X	X	X	X	X	X	X	X	X	X
33603	Amedisys Hospice an Adventa Company	X	X	X	X	X	X		X	X	X	X
33643	Avalon Hospice	X	X	X	X	X	X		X	X	X	X
33653	Caris Healthcare	X	X	X	X	X	X			X	X	X
33673	Hearth Hospice of Tennessee	X	X	X	X	X	X		X	X	X	X
33613	Hospice of Chattanooga Inc	X	X	X	X	X	X		X	X	X	X
47602	Amedisys Hospice an Adventa Company	X	X	X		X	X	X	X	X	X	X
47682	Caris Healthcare					X		X				X
47402 & 47632	Covenant Homecare							X				X
47132 & 47662	UTMCK-Home Care Services: Hospice & Home Care							X				X
71604	Kindred Hospice	X										X
	TOTAL LICENSED	**9**	**9**	**9**	**7**	**10**	**9**	**7**	**8**	**8**	**8**	**14**

Source: TN Department of Health Licensure - 2/17/2023

In total, there were 6,926 patients served in 2022, 6,912 by the above licensed providers and 14 others. Of the 6,926 total in-home hospice admissions, there were 3,524 admissions in Hamilton County, which represents more than one-half of the Service Area admissions. The next greatest County was Bradley with 1,010 admissions. The other eight counties ranged between 95 and 586 admissions, each representing less than 8.5 percent of total Service Area patients. All in-home hospice providers are presented on the following table along with 2022 patients served by county.

Patients Served by Hospice and County (Licensed and Unlicensed)
Fiscal Year 2022

State ID	Hospice Agency	Bledsoe	Bradley	Hamilton	Marion	McMinn	Meigs	Monroe	Polk	Rhea	Sequatchie	Total
05602	Blount Memorial Hospital Hospice	NL	NL	NL	NL	NL	NL	10	NL	NL	NL	10
06063 & 06613	Adoration Home Health & Hospice Care East TN	10	208	296	48	55	31	134	51	31	34	898
06603	Kindred Hospice	NL	44	164	NL	20	10	NL	6	NL	NL	244
19694	Avalon Hospice	7	0	206	23	3	1	21	0	15	5	281
33603	Amedisys Hospice an Adventa Company	39	114	493	85	201	27	10	41	187	77	1,274
33643	Avalon Hospice	0	0	14	0	0	0	NL	0	0	1	15
33653	Caris Healthcare	4	22	32	4	43	7	17	NL	1	4	134
33673	Hearth Hospice of Tennessee	23	269	905	77	104	13	NL	12	136	25	1,564
33613	Hospice of Chattanooga Inc	11	352	1407	92	158	57	1	23	87	74	2,262
47602	Amedisys Hospice an Adventa Company	0	0	1	NL	1	5	125	48	0	0	180
47682	Caris Healthcare	NL	NL	NL	NL	0	NL	5	NL	NL	NL	5
47402 & 47632	Covenant Homecare	NL	NL	NL	NL	NL	NL	11	NL	NL	NL	11
47132 & 47662	UTMCK-Home Care Services: Hospice & Home Care	NL	NL	NL	NL	NL	NL	34	NL	NL	NL	34
71604	Kindred Hospice	0	NL	NL	NL	NL	NL	NL	NL	NL	NL	0
	TOTAL PATIENTS, LICENSED	**94**	**1,009**	**3,518**	**329**	**585**	**151**	**368**	**181**	**457**	**220**	**6,912**
	Unlicensed Providers' Patients (In-Home)	1	1	6	0	1	2	3	0	0	0	14
	TOTAL PATIENTS, WITHOUT RESIDENTIAL	**95**	**1,010**	**3,524**	**329**	**586**	**153**	**371**	**181**	**457**	**220**	**6,926**

Source: Fiscal Year 2022 Hospice Master File; List of Agencies provided by TN Department of Health Licensure 2/17/2023.
NL = Not Licensed in that County. Note, these exclude any admissions by residential hospices from these counties.

The next table summarizes patients served by in-home agency for each of the last three years. In 2020 there were 6,422 in-home hospice admissions; admissions grew 7.6 percent to 6,926 in 2022.

Patients Served by Hospice Agency within the Service Area Counties
Years 2020, 2021 and 2022

State ID	Hospice Agency	2020	2021	2022	Change	Percent Change
05602	Blount Memorial Hospital Hospice	26	26	10	-16	-61.5%
06063 & 06613	Adoration Home Health & Hospice Care East TN	212	346	898	686	323.6%
06603	Kindred Hospice	314	295	244	-70	-22.3%
19694	Avalon Hospice	379	256	281	-98	-25.9%
33603	Amedisys Hospice an Adventa Company	793	769	1,274	481	60.7%
33643	Avalon Hospice	18	25	15	-3	-16.7%
33653	Caris Healthcare	154	90	134	-20	-13.0%
33673	Hearth Hospice of Tennessee	1,243	1,454	1,564	321	25.8%
33613	Hospice of Chattanooga Inc	2,737	3,231	2,262	-475	-17.4%
47602	Amedisys Hospice an Adventa Company	253	109	180	-73	-28.9%
47682 (*)	Caris Healthcare	231	246	5	-226	-97.8%
47402 & 47632	Covenant Homecare	14	6	11	-3	-21.4%
47132 & 47662	UTMCK-Home Care Services: Hospice & Home Care	47	38	34	-13	-27.7%
71604	Kindred Hospice	0	0	0	0	--
	TOTAL, Licensed Hospice Agency Patients	**6,421**	**6,891**	**6,912**	**491**	**7.6%**
	Unlicensed Providers' Patients (In-Home)	1	4	14	13	--
	Total, Licensed and Unlicensed	**6,422**	**6,895**	**6,926**	**504**	**--**

Source: Fiscal Year 2020 - 2022 Hospice Master File; List of Agencies provided by TN Department of Health Licensure 2/17/2023
(*) Note Caris 47682 includes Caris McMinn 54603 in McMinn, Meigs, Monroe, Polk, and Rhea Counties in 2020.
(*) Note Caris 47682 includes Caris McMinn 54603 in Bradley, McMinn, Meigs, Monroe, Polk, and Rhea Counties in 2021

Hospice of Chattanooga (33613) based in Hamilton County has the largest hospice program in the Service Area admitting 32.7 percent of total volume in 2022. However, this was a decrease of nearly 1,000 patients between 2021 and 2022, and a decrease of 475 patients in the two year period. Hospice of Chattanooga was acquired by an equity fund during this period.

The next highest market share is Hearth Hospice of Tennessee (33673) (22.6 percent of total). The next in size is Amedisys (33603) with 1,274 admissions or 18.4 percent of total, followed by Adoration (06613) with 13 percent of total. In aggregate, these four providers admit more than 86 percent of the Service Area. Of the four, three are based in Hamilton County and one is based in Bradley County. The remaining ten agencies share the other 13.4 percent of admissions ranging between 0 and 281 admissions.

Please refer to **Attachment 5N** for the 2020, 2021 and 2022 list of licensed hospice agencies serving each of these counties provided by the Health Facilities Commission.

With Heritage Hospice's unique focus on lifting up the Black penetration rate in the Service Area, the Applicant should have no negative impact on existing providers. More importantly, the Applicant will provide significant Consumer Advantage in terms of Choice, Improved Accessibility and Availability.

6N. Provide applicable utilization and/or occupancy statistics for your institution services for each of the past three years and the project annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

RESPONSE:

Heritage Hospice is a newly formed entity with the purpose of establishing hospice services in southeast Tennessee therefore it has no historical utilization. While the Applicant has no operational history, its leadership have spent considerable time studying the Service Area, racial disparities and market dynamics. Based on its study, it engaged with community constituents throughout the Service Area to discuss the racial disparities, how it will address such disparities and solicit community input, market validation and support for this CON Application and its future efforts.

Its thorough analysis of quantifying the underserved Black population was presented in Question 4N in its presentation of the racial disparities and identifying the underserved Black population on an annual basis. Those computations resulted in an identified shortfall of between 224 and 259 end of life Black patients. It is the Applicant's intent to admit all eligible persons seeking admission at Heritage Hospice regardless of race or ethnicity and will serve all patients equally. However, by virtue of the fact that Heritage Hospice's mission is to lift up the hospice penetration rate for Black population to minimize and/or eliminate racial disparities in end of life hospice care, it believes a majority (more than half) of its hospice patients will be Black.

While the computed shortfall is a first step in estimating future utilization at Heritage Hospice, the Applicant understands dispelling of decades long disparity is not an overnight (or even two-year task). Accordingly, it is the Applicant's goal to eliminate or minimize the overall disparity during the next five or so years, with mitigating at least half of the disparity in its second year of operation. Accordingly, it projects the following year one and year two admissions:

- Year One: Total 108 admissions with 55 Black admissions (51 percent of total)
- Year Two: Total 222 admissions with 128 Black admissions (58 percent of total)

The constituents confirming racial disparities, supporting the approval of Heritage Hospice's CON Application and which will be both educational and referral sources include the following (as of this date).

Health Systems and Physicians:

- Angel Moore, CEO, Erlanger Health Centers, Erlanger Health System
- Dr. Andrew Alward, NewTread Podiatry, Hamilton County
- Dr. Christopher Prater, Hamilton County
- Dr. Anthony G. Avitabile, Hamilton County

Nursing Homes and Assisted Living Facilities:

- The Waters of Sweetwater Rehab and Nursing Center, Monroe County SNF
- Decatur Wellness and Rehabilitation Center, Meigs County SNF
- Soddy Daisy Healthcare Center, Hamilton County SNF
- Morningside of Cleveland, Bradley County ALF
- The Lanterns Alzheimer's Center, Hamilton County ALF
- Brookdale Mount Vernon Drive, Bradley County ALF
- Dominion of Hixson, Hamilton County ALF
- Garden Plaza at Cleveland, Bradley County ALF
- American House Shallowford, Hamilton County ALF (2 letters)
- American House Hamilton Place, Hamilton County ALF

Community Organizations/Persons:

- Urban League of Greater Chattanooga Area, Greg Funderburg, Marketing Director
- Nivaq Ministries International, Gavin Lynn Steward
- Smith Bone Consulting Group, Vickye Bone, Former VP Urban League of Greater Chattanooga

In terms of quantification, most of the referrals in the above letters were qualitative. However, six letters attempted to quantify their estimated referrals, albeit on a conservative basis. Two of the quantified letters, both nursing homes, identified 36 annual admissions plus additional admissions by their physicians. Three letters were from assisted living facilities; and combined between the facilities and their relationships, estimated between 72 and 84 annual admissions. Lastly, one physician estimated between 1 and 2 referrals per month (12 to 24 per year). In aggregate, these six supporters total between 120 and 144 annual admissions. Erlanger Health System, the largest safety net provider in the region, provided its support without quantification. Given the diversity of letters identified above including hospitals, physicians, nursing homes, assisted living facilities, Black ministries and the Urban League, Heritage Hospice is well positioned to achieve its forecasted admissions and lift up the Black hospice penetration rate in the Service Area.

Projected Utilization

Based on the detailed analysis presented in **Question 4N**, and the resulting conclusions summarized above, Heritage Hospice forecasts to admit 108 patients in year one and 222 patients in year two. The details of the services to be provided, admissions by location of care, admissions by county, and patient days by level of service are presented on the following pages.

Level of Hospice Service to be Provided

In accordance with Medicare Conditions of Participation (COPs), Heritage Hospice will provide each of the four levels of hospice care as deemed necessary and appropriate by the Interdisciplinary Team (IDT). Each of these four levels are identified in the following table with confirmation by Heritage Hospice that each will be available and provided.

Levels of Hospice to be Provided by Heritage Hospice

Hospice Levels of Care	Yes	No
Routine Home Care	X	--
General Inpatient Care	X	--
Continuous Home Care	X	--
Respite Care	X	--

Policies and procedures associated with these levels are included in the **Attachment 1N-6** to this CON Application. Additionally, a sample facility contract for inpatient and respite care is provided in **Attachment 1C.**

Location of Hospice Service

Heritage Hospice has spent considerable time this year meeting with referral sources and organizations to identify the underserved Black population in the Service Area. As part of this effort, Heritage Hospice has garnered support from various people and organizations throughout the Service Area. This includes hospital, nursing homes, assisted living facilities, ministries, and others, including the Urban League. Based on its initial investigation and support for Heritage Hospice to elevate Black hospice penetration in the Service Area, Heritage Hospice estimates the distribution of its initial years' patients to reside and receive treatment in the locations identified in the below table.

Location of Hospice Care to be Provided by Heritage Hospice

Location of Care	Yes	No	% of Patients
Home	X	--	40%
Assisted Living Facility	X	--	22%
Nursing Facility	X	--	Below
Skilled Nursing Facility	X	--	35%
Inpatient Hospital Facility	X	--	1%
Other (*)	X	--	2%

(*) Group homes, shelters and other locations.

As Heritage Hospice continues to develop relationships in the future, the percentage distribution of patients by location of care may evolve from that projected above.

Forecasted Admissions and Patient Days

Based on the detailed assessment provided in this CON application, including historical hospice utilization, historical and projected hospice deaths, analysis of Black and other hospice penetration rates for both Medicare and total, and identified racial disparities in the Service Area, the Applicant's has projected the annual number of patients by county to be admitted during the first two years of operation. This is provided below.

Service Area County	Year 1		Year 2	
	Admissions	% of Total	Admissions	% of Total
Bledsoe	8	7.4%	12	5.4%
Bradley	14	13.0%	29	13.1%
Hamilton	66	61.1%	132	59.5%
McMinn	3	2.8%	12	5.4%
Marion	9	8.3%	20	9.0%
Meigs	1	0.9%	3	1.4%
Monroe	2	1.9%	5	2.3%
Polk	2	1.9%	3	1.4%
Rhea	2	1.9%	4	1.8%
Sequatchie	1	0.9%	2	0.9%
Total, Admissions	108	100.0%	222	100.0%
Average Length of Stay	39.0	--	56.6	--
Patient Days	4,209	--	12,570	--

It should be noted the average length of stay in the above chart is a mathematical computation and is the result of a blend of short stay and long stay patients. The current average length of stay for the providers in the Service Area is slightly greater than 70 days. However, the Applicant recognizes the average length of stay for the Black population is less due to a later entry into the hospice model of care. Heritage Hospice will work on increasing the length of stay and seeking to admit the Black population earlier in the terminal diagnosis period.

In the initial year of operation, there are a couple of factors impacting the overall length of stay and causing it to be 39 days. First, typically in the first six months, the new admissions are those further along in their end of life journey as the agency to meet their needs may not have been available (licensed or certified) when optimal timing to select hospice would have occurred. Therefore, in the first year there are many more short stay hospice patients than in the later years. Second, the percentage of patients who maximize the hospice benefit of six months increases over time. As part of this, in the first year, the longer stay patients may still be on service at the end of the year, depending upon when admitted during the year, thereby distorting the overall length of stay as the entirety of their patient stay (days) are not included in the year's patient days (as they happen in year two). Then in the second year, those patients admitted in year one, remain treated with patient days in year two (although admission counted in year one). As a result, the percentage of longer stay patients continues to increase. When agencies achieve stabilization, the length of stay is then typically constant but in the initial growth period, the above increase between year one and year two is reflective of a start up business.

Level of care for the above admissions and patient days by year are presented in the table below. It is likely that all patients at some time during their hospice treatment will be on routine care and some may be admitted to a hospital for short term pain management for a stay of 3 to 5 days. Accordingly, while patients are distributed in the below chart based on 98 percent routine patient days, 1 percent general inpatient and 1 percent respite, it is likely the number of patients admitted to a hospital will range between 8 and 10 in year one and up to 25 to 30 in year two and that nearly 100 percent of patients will be on routine care.

Hospice Levels of Care	Patients, Year 1	Patient Days, Year 1	Patients, Year 2	Patient Days, Year 2	Total Patients Year 1 - Year 2	Total Patient Days Year 1 - Year 2	% Change Patients Year 1 - Year 2	% Change Patient Days Year 1 - Year 2
Routine Home Care	106	4,125	218	12,319	112	8,194	105.6%	198.6%
General Inpatient Care	1	42	2	126	1	84	105.6%	198.6%
Continuous Home Care	0	0	0	0	0	0	--	--
Respite Care	1	42	2	126	1	84	105.6%	198.6%
Total	108	4,209	222	12,570	114	8,361	105.6%	198.6%

(*) The Applicant will provide continuous care in accordance with Medicare Conditions of Participation as noted. It has been its experience that when pain is properly managed in the home setting, continuous care services are not regularly required by its patients. This process also minimizes any inpatient hospital utilization.

Given the Applicant's extensive industry experience and goal of meeting the needs of the Service Area underserved population identified in the needs analysis of this CON Application, the projected utilization is reasonable and achievable and will simultaneously lift up the underserved hospice eligible patients in the Service Area.

7N.

CON Number	**Project Name**	**Date Approved**	**Expiration Date**

- ➢ Complete the above chart by entering information for each applicable outstanding CON by applicant or share common ownership; and
- ➢ Describe the current progress and status of each applicable outstanding CON and how the project relates to them.

RESPONSE:

Heritage Hospice has no outstanding CONs for hospice or any other regulated service in the State of Tennessee.

CONSUMER ADVANTAGE ATTRIBUTED TO COMPETITION

The responses to this section of the application helps determine whether the effects attributed to competition or duplication would be positive for consumers within the service area.

1C. List all transfer agreements relevant to the proposed project.

RESPONSE:

Heritage Hospice will contract with service area nursing homes, hospitals and assisted living facilities to meet the needs of its patients who are not residing in a private residence. The Applicant does not build freestanding hospice facilities and does not intend to do so in Tennessee. This allows the patient to remain in the same facility and seamlessly transition to hospice, in place. This is better continuity of care for the patient and for the family.

A sample inpatient hospice services agreement to be used by Heritage Hospice is included in Attachment 1C.

2C. List all commercial private insurance plans contracted or plan to be contracted by the applicant.

RESPONSE:

The majority of Heritage Hospice's patients will be Medicare and TennCare. It is Heritage Hospice leadership experience that until a hospice is credentialed to provide services, there is not the specific need to contact these organizations, nor do these entities engage in preliminary dialogue. The managed care organizations will seek the Medicare and Medicaid providers numbers to initiate credentialing so until licensed those are not available. Based on its research of the existing insurance plans in the Service Area, Heritage Hospice expects it will contract with the following plans.

Commercial Insurance Plans
- Bright Healthcare
- Ambetter of Tennessee
- Aetna
- Blue Cross Blue Shield
- Cigna Healthcare
- United Healthcare
- Oscar Insurance Company
- Humana

Managed Care
- Amerigroup
- BlueCare
- UnitedHealthcare Community Plan
- TennCare Select

Heritage Hospice will reach out to each Medicaid managed care organization and other managed care providers to become credentialed and execute a contractual arrangement to serve any enrollees of those entities.

3C. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact upon consumer charges and consumer choice of services.

RESPONSE:

Heritage Hospice's mission is to lift up the hospice penetration rate for Black population to minimize and/or eliminate racial disparities in end of life hospice care. No other hospice in the Service Area has this as its mission. In fact, Ms. Hamilton states: *My passion has always been to have a positive impact in healthcare by ensuring that quality care is available and received to all in need. I have suffered many personal losses during this time, but my most devastating loss was my son 4/3/21 to gun violence. Not knowing if he suffered, if he was alone in that last moment, and if he was treated with dignity and respect as he transitioned is painful. However, this experience has allowed me to have an in-depth understanding of the many roads to grief and healing. Heritage hospice is MY PURPOSE. Heritage will allow me to walk in the midst of grief and walk with the families to peace and healing. I believe life is precious and dying in peace with dignity and respect while adhering to patients' request of where this should take place is the most important part of a person's life legacy. Dying should be precious as well. Heritage is the new beginning of what's missing in hospice."*

Ms. Hamilton and Heritage Hospice will bring a fresh perspective to hospice in southeast Tennessee. As a nurse, hospice administrator and advocate for the Black patient receiving proper end of life care, she will assure her vision, mission and objectives are met in the Service Area. Her passion to reaching underserved minorities is evident in her garnering constituent support from throughout the Service Area. Ms. Hamilton's efforts are on-going and will continue until the CON Application is approved, and then escalate thereafter.

The Heritage Hospice proposal will foster competition through innovative approaches to marketing, education and service delivery for the Black and other minority populations. The goal is to reach new consumers that heretofore have not had any choices due to mistrust of the healthcare system, lack of knowledge, lack of access, or misunderstanding of the hospice level of care. These barriers to hospice care for the Black population are well-documented. Heritage Hospice will engage with the community to reduce and/or eliminate these barriers. The impact on the consumer and consumer choice will be evident and demonstrated through increased Black hospice penetration in the Service Area.

In addition to its Black patients, a minority of Heritage Hospice patients will be white or other minorities. Heritage Hospice will enhance access in this Service Area through providing consumers with an alternative choice to meet their end of life in-home hospice needs. Heritage Hospice will promote quality through its staffing models which exceed NHPCO minimum requirements. This is based on Ms. Hamilton's experience at various other agencies and the resulting impact on overcoming barriers and obstacles of service while simultaneously promoting quality care. This results in enhancement of quality of care with consumer advantage in mind.

The approval of Heritage Hospice will not have any negative effect on existing providers as its hospice is targeting a very specific population and its admissions represent between 1.5 and 3 percent of overall admissions in the Service Area. Since the vast majority of hospice care services are reimbursed through set rates established by Medicare, Medicaid, or Commercial Insurance providers, Heritage Hospice's introduction will have no impact on consumer charges while offering an additional access point to enhance end of life quality without increasing the cost to the consumer.

4C. Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements, CMS, and/or accrediting agencies requirements, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

RESPONSE:

The Applicant is confident there are available and accessible clinical professionals and support staff in the defined Service Area to adequately staff its hospice agency. This includes registered nurses. According to Tennessee.gov, in 2023 there were more than 10,900 registered nurses residing in the Applicant's Service Area. The 2023 inventory of registered nurses is greater than the prior year of 10,833 RNs and two years prior of 10,603 RNs. The 2-year change represents a 2.9 percent increase, with every county experiencing an increase during this period. The growth in RN inventory within the Service Area is illustrated next.

Registered RN Inventory in Heritage Hospice Service Area
2021 through 2023 by Service Area County

County	2021	2022	2023	2-Year Change
Bledsoe	121	120	126	4.1%
Bradley	1,501	1,567	1,573	4.8%
Hamilton	6,843	6,941	6,981	2.0%
McMinn	562	575	582	3.6%
Meigs	119	124	130	9.2%
Monroe	428	433	435	1.6%
Polk	209	218	221	5.7%
Rhea	268	281	287	7.1%
Sequatchie	182	185	190	4.4%
Service Area	**10,603**	**10,833**	**10,912**	**2.9%**

Source: https://tnmap.tn.gov/health/nursing

As a nurse, Ms. Hamilton understands nursing education is the bedrock for growing the population of skilled nurses. There are at least 12 professional nursing schools within and around the service area that Heritage Hospice will seek to establish relations with to provide training in the provision of end of life care to the region's future nurses. The schools identified are identified in **Attachment 1N, Criterion #2**.

A key element in the delivery of quality patient care is the quality of its staff. Heritage Hospice will place heavy emphasis on recruiting and maintaining high-quality professional staff. Effectiveness in meeting this goal results from a combination of competitive wages and employee benefits, education and training and performance evaluation. Staff training is integral to the delivery of quality care. All personnel will actively participate in the staff training programs and will be specifically trained on overcoming racial disparities in the provision of end of life hospice care.

The Applicant is confident that it will have an available and accessible pool of highly qualified and highly skilled individuals to build its hospice team.

5C. Document the category of license/certification that is applicable to the project and why. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

RESPONSE:

Licensure: Health Facilities Commission, Tennessee Department of Health

Certification Type: Medicare Certified and TennCare/Medicaid Certified

Accreditation: The Applicant will seek Community Health Accreditation Partner (CHAP) accreditation as soon as practical after licensure. It is anticipated that accreditation will be achieved within 90 days of licensure.

By becoming accredited, Heritage Hospice will meet or exceed CHAP Standards of Excellence and demonstrate a commitment to providing quality patient care and services. CHAP accreditation is an independent, not for profit accrediting body for community health programs such as home healthcare agencies and hospice care. CHAP is the leader in improving the quality of community based healthcare services.

Other objective measurements available for quality include the Hospice Quality Reporting Program ("HQRP"), which currently consists of CMS reporting requirements, Hospice Item Set ("HIS"), Hospice Care Index ("HCI") and Hospice Consumer Assessment of Healthcare Providers and Systems ("CAHPS") survey. Heritage Hospice will use this data to benchmark its agency against peers and thereby determine areas where a specific hospice agency needs improvement. The analysis and comparison of this data provides an objective analysis of specific metrics which contribute to overall quality. The positive impact of this methodology will be seen in the quality performance of Heritage Hospice once licensed.

For each category of employee which requires individual licensure and continuing education credits, the Applicant will assure compliance and ongoing maintenance of both license and required credentials and assure documentation is properly maintained.

6C. See INSTRUCTIONS to assist in completing the following tables.

☐ Project Only
☐ Total Facility

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency.

		Year_____	**Year_____**	**Year_____**
A.	Utilization Data			
	Specify Unit of Measure ______________	________	________	________
B.	Revenue from Services to Patients			
	1. Inpatient Services	$________	$________	$________
	2. Outpatient Services	________	________	________
	3. Emergency Services	________	________	________
	4. Other Operating Revenue (Specify)__________________	________	________	________
	Gross Operating Revenue	$________	$________	$________
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	$________	$________	$________
	2. Provision for Charity Care	________	________	________
	3. Provisions for Bad Debt	________	________	________
	Total Deductions	$________	$________	$________
NET OPERATING REVENUE		$________	$________	$________

RESPONSE:

The Applicant has no operating history. Therefore, this is not applicable.

RESPONSE:

X Project Only
X Total Facility

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal.

			Year 1 (2024)	**Year 2 (2025)**
A.	Utilization Data			
	Specify Unit of Measure Patient Days:		4,209	12,570
B.	Revenue from Services to Patients			
	1. Inpatient Services		$__________	$__________
	2. Outpatient Services		$789,534	$2,393,278
	3. Emergency Services		__________	__________
	4. Other Operating Revenue (Specify)____________		__________	__________
		Gross Operating Revenue	**$789,534**	**$2,393,278**
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments		$15,791	$47,866
	2. Provision for Charity Care		$40,019	$71,798
	3. Provisions for Bad Debt		$3,948	$11,966
		Total Deductions	$49,758	$131,630
NET OPERATING REVENUE			$729,776	$2,261,648

Patient days for the proposed project are a function of the number of admissions projected and the average length of stay for each admission. Admissions were conservatively derived from the detailed analysis presented herein. The average length of stay was derived from evaluating the Service Area length of stay, Heritage Hospice leadership prior experience and including certain adjustments to account for meeting the needs of the underserved Black population.

Patient Service Revenue for the proposed hospice agency is projected based on the Medicare payment rates by hospice level of service. The projected distribution of hospice revenue is consistent with leadership experience and what is expected in the Service Area. Based on prior experience opening hospice agencies in other markets, Heritage Hospice has projected that it will receive Medicare certification from CMS in four months after initiating services and Medicaid certification within 60 days thereafter. As a result, no revenues for these payors will be incurred during this timeframe.

The contractual adjustments are derived from prior experience. Bad debt is also derived from the experience of leadership taking into account the income and poverty levels in the Service Area and is estimated to be 0.5 percent of total net revenue. Charity care is estimated to be 3 percent of gross operating revenue in year two and ongoing; year one charity care includes the pre-certification write offs so exceeds 5 percent of gross revenues.

7C. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Historical and Projected Data Charts of the proposed project.

RESPONSE:

Project Only Chart

	Previous Year to Most Recent Year Year ____	Most Recent Year Year____	**Year One Year 2024 Per Patient Day**	**Year Two Year 2025 Per Patient Day**	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	N/A	N/A	$187.58	$190.40	1.5%
Deduction from Revenue *(Total Deductions/Utilization Data)*	N/A	N/A	$14.20	$10.47	(26.3%)
Average Net Charge *(Net Operating Revenue/Utilization Data)*	N/A	N/A	$173.38	$179.93	3.8%

Based on Heritage Hospice's experience, it has projected that it will receive Medicare certification from CMS four months after initiating services. As a result, no revenues for these payors will be incurred prior to this timeframe and average deductions from revenues are greater and average net charges for the project are lower in Year 1 than in Year 2. Charges are a function of the type of revenue requested divided by patient days and incorporate inflation of 1.5 percent.

8C. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

RESPONSE:

Medicare is the primary payor for hospice services. Annually Medicare sets the actual reimbursement by level of hospice care, depending on one of the four levels of service (routine, inpatient, respite and continuous care). These rates are then adjusted for local wage indices throughout the country. Private payors and Medicaid typically base their reimbursement on the Medicare rates, either consistent with or a percent of Medicare. The Applicant's charges are based on Medicare reimbursement. For year one, they are estimated to be $190.57 for routine days 1-60 and $150.58 for routine days 60+. Inpatient care is estimated to be $1,006.33 per day. Respite care is estimated at $447.95 per day which is the Medicare rate and continuous care is set at $56.18 per hour which is also the Medicare rate. Given there is no rate disparity for Medicare amongst providers within the same geography, there is no competitive effect of these rates on either patient charges or the existing market dynamic for pricing.

9C. Compare the proposed project charges to those of similar facilities/services in the service area/adjoining services areas, or to proposed charges of recently approved Certificates of Need.

If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

RESPONSE:

The charge structure for hospice services is typically established from Medicare reimbursement formulas based on the designated level of service. Accordingly, most hospices utilize the same pricing and there are not distinguishable differences amongst providers. Proposed charges utilized in the Projected Data Chart are based on Medicare reimbursement and are therefore reasonable in comparison with charges of other hospice agencies in the service area, and the remainder of Tennessee. The Applicant anticipates a net charge of $173 per patient day for the first year of operation and $180 per patient day in the second year of operation. Year one is reduced due to write off of pre-certification revenues and therefore not an appropriate comparison to operational hospices. As demonstrated below, the Applicant's year two charges compare favorably to those of other service area providers.

Demonstrated below, the Applicant's year one and year two charges compare favorably to those of other service area providers. Below are the fiscal year 2022 charges of area providers and the corresponding 2025 charges for the Applicant.

Rates by Hospice Agency within the Service Area Counties
Fiscal Year 2022

State ID	Hospice Agency	Routine	Continous	Inpatient	Respite
05602	Blount Memorial Hospital Hospice	$172	$1,236	$912	$411
06063 & 06613	Adoration Home Health & Hospice Care East TN	$177	$1,248	$933	$416
06603	Kindred Hospice	$177	$1,243	$933	$416
19694	Avalon Hospice	$186	$1,322	$982	$437
33603	Amedisys Hospice an Adventa Company	$149	$500	$886	$417
33643	Avalon Hospice	$183	$1,303	$970	$432
33653	Caris Healthcare	$184	$1,303	$970	$432
33673	Hearth Hospice of Tennessee	$192	$1,380	$1,010	$447
33613	Hospice of Chattanooga Inc	$177	$1,396	$936	$420
47602	Amedisys Hospice an Adventa Company	$146	$500	$911	$403
47682 (*)	Caris Healthcare	$177	$1,243	$933	$416
47402 & 47632	Covenant Homecare	$177	$1,242	$933	$416
47132 & 47662	UTMCK-Home Care Services: Hospice & Home Care	$153	$1,236	$1,077	$402
71604	Kindred Hospice	$177	$1,243	$933	$416
Average, Licensed Hospice Agency, FY2022		**$162**	**$1,093**	**$888**	**$392**
Average, Licensed Hospice Agency in Service Area, FY2022		**$177**	**$1,196**	**$948**	**$426**
Heritage Hospice and Palliative Care, FY 2025		**$153-$193**	**$57/hour**	**$1,021**	**$455**

Source: Joint Annual Reports by Provider, Page 6, FY 2022 with exception of Blount Memorial, Hearth Hospice and Hospice of Chattanooga; these latter three are 2021 as 2022 is not available.
The range in routine is for the 1-60 day and 60+ day routine payments; the resulting average is based on mix of patients.

The charges above are based on Medicare established rates as reported in each hospice's Joint Annual Report. These rates are established by Medicare and fairly consistently used universally by all payor types. Differences in routine rates among providers are (1) based on the geography of the patient's residence; and (2) the mix of patient days in the 1-60 or 60+ day category. Medicare reimbursement decreases after the 60th day. While mix of patients in the routine categories is not evident from the information, those hospices based in the Service Area counties (highlighted in yellow) have higher average routine charges per day than the 14 licensed providers. Additionally, continuous care is paid on an hourly basis. The $1,093 to $1,196 rate is derived from a 24-hour encounter; the lower rate is likely and 8 to 10 hour experience by that particular provider.

Based on the above charges, and Medicare rates as published by CMS adjusted for geography, Heritage Hospice's Year 2 (2025) is on par with the Service Area provider's average net revenue per patient day. Specifically, in 2022 the routine rate of $162 overall, or $177 for the Service Area hospices, inflated by three years to the forecasted time frame, results in $177 to $193 per day for routine days. Heritage Hospice's forecast of $180 is reasonable and takes into account 98 percent routine, 1 percent respite and 1 percent inpatient. In addition to reasonable charges, the Applicant will treat any hospice eligible patient in the Service Area seeking admission at Heritage Hospice without regard to the person's ability to pay.

10C. Discuss the project's participation in state and federal revenue programs, including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. Report the estimated gross operating revenue dollar amount and percentage of project gross operating revenue anticipated by payor classification for the first and second year of the project by completing the table below.

RESPONSE:

The following chart provides the Applicant's projected payor mix for each of the first two years of operation:

Applicant's Projected Payor Mix
Project Only Chart

Payor Source	Year 1		Year 2	
	Gross Operating Revenue	% of Total	Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care	$702,136	88.9%	$2,128,350	88.9%
TennCare/Medicaid	65,549	8.3%	198,696	8.3%
Commercial/Other Managed Care	14,566	1.9%	44,155	1.9%
Self-Pay	7,283	0.9%	22,077	0.9%
Other (Specify)________________				
Total*	$789,534	100.0%	$2,393,278	100.0%
Charity Care	$40,019	▨	$71,798	▨

**Needs to match Gross Operating Revenue Year One and Year Two on Projected Data Chart*

The proposed hospice agency's projected payor mix for the first two years of operation was based on an evaluation of the Service Area and Heritage Hospice's focus in meeting the underserved need of the Black population. The majority of patient days are generated from Medicare recipients. Heritage Hospice's sample charity care policy is supplied as **Attachment 1N-5**.

QUALITY STANDARDS

1Q. Per PC 1043, Acts of 2016, any receiving a CON after July 1, 2016, must report annually using forms prescribed by the Agency concerning appropriate quality measures. Please attest that the applicant will submit an annual Quality Measure report when due.

RESPONSE:

The Applicant attests it will submit an annual Quality Measure report when due, consistent with PC 1043, Acts of 2016.

2Q. The proposal shall provide health care that meets appropriate quality standards. Please address each of the following questions.

- Does the applicant commit to maintaining the staffing comparable to the staffing chart presented in its CON application?
- Does the applicant commit to obtaining and maintaining all applicable state licenses in good standing?
- Does the applicant commit to obtaining and maintaining TennCare and Medicare certification(s), if participation in such programs are indicated in the application?

RESPONSE:

The Applicant commits to maintaining the staffing comparable to the staffing chart presented on page 45 of this Application. The proposed staffing will meet or exceed NHPCO Guideline for Staffing in each of the first two years of operation and beyond. The Applicant also commits to obtaining and maintaining all applicable state licenses and remain in good standing. The Applicant will obtain and maintain TennCare and Medicare certifications.

Concurrent with licensure and certification, the Applicant will develop all policies and procedures and the quality assurance program based on other its leaderships' operating experience and consistent with the samples provided in **Attachment 1N-6**. Upon licensure and certification, the Applicant will adhere to all state and federal regulations and statutes and will comply with the Conditions of Participation for hospice providers of services under the Health Insurance for the Aged and Disabled Program (Title XVIII of the Social Security Act) and will participate in the TennCare/Medicaid Program.

Heritage Hospice is committed to the appropriate provision of comprehensive, high quality, safe, and cost-effective hospice care to persons who are terminally ill and in need of such services with the primary objective of lifting up the Black hospice penetration rate in the Service Area. Notwithstanding this objective, it is the Applicant's intent to admit all eligible persons seeking admission regardless of race or ethnicity and will serve all patients equally.

3Q. Please complete the chart below on accreditation, certification, and licensure plans. Note: if the applicant does not plan to participate in these type of assessments, explain why since quality healthcare must be demonstrated.

RESPONSE:

Credential	Agency	Status (Active or Will Apply)	Provider Number or Certification Type
Licensure	**X** Health Facilities Commission ○ Intellectual & Developmental Disabilities ○ Mental Health & Substance Abuse Services	Will Apply	Pending
Certification	**X** Medicare **X** TennCare/Medicaid ○ Other: ____________	Will Apply Will Apply	Pending Pending
Accreditation(s)	**X** – CHAP Accreditation	Will Apply	Pending

4Q. If checked "TennCare/Medicaid" box, please list all Managed Care Organization's currently or will be contracted.

RESPONSE:

The majority of Heritage Hospice's patients will be Medicare and TennCare. It is Heritage Hospice leadership experience that until a hospice is credentialed to provide services, there is not the specific need to contact these organizations, nor do these entities engage in preliminary dialogue. The managed care organizations will seek the Medicare and Medicaid providers numbers to initiate credentialing so until licensed those are not available. Based on its research of the existing insurance plans in the Service Area, Heritage Hospice expects it will contract with the following Medicaid managed care plans.

- Amerigroup
- BlueCare
- UnitedHealthcare Community Plan
- TennCare Select

Heritage Hospice will reach out to each Medicaid managed care organization and other managed care providers to become credentialed and execute a contractual arrangement to serve any enrollees of those entities.

5Q. Do you attest that you will submit a Quality Measure Report annually to verify the license, certification, and/or accreditation status of the applicant, if approved?

X Yes ☐ No

6Q. For an existing healthcare institution applying for a CON:

- Has it maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action should be discussed to include any of the following: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions and what measures the applicant has or will put into place to avoid similar findings in the future.
- Has the entity been decertified within the prior three years? If yes, please explain in detail. (This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility.)

RESPONSE:

This is not applicable as Heritage Hospice and Palliative Care is not an existing healthcare institution.

7Q. Respond to all of the following and for such occurrences, identify, explain, and provide documentation if occurred in last five (5) years.

Has any of the following:

- Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);
- Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

Been subject to any of the following:

- Final Order or Judgement in a state licensure action;
- Criminal fines in cases involving a Federal or State health care offense;
- Civil monetary penalties in cases involving a Federal or State health care offense;
- Administrative monetary penalties in cases involving a Federal or State health care offense;
- Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services;
- Suspension or termination of participation in Medicare or TennCare/Medicaid programs; and/or
- Is presently subject of/to an investigation, or party in any regulatory or criminal action of which you are aware.

RESPONSE:

No entity or party meeting the specified ownership criteria has been subject to any of the items listed above.

8Q. Provide the project staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions.

RESPONSE:

The following chart provides the FTEs by position for year one of operation of the Applicant. Since this CON request is to establish a new in home hospice service, there are no existing FTEs.

Position Classification	**Existing FTEs**	**Projected FTEs Year 1**
A. Direct Patient Care Positions		
Director of Nursing	N/A	1.0
On-Call Nurse	N/A	1.0
RN	N/A	2.0
Aide (CNA)	N/A	1.8
Social Worker	N/A	1.0
Chaplain	N/A	1.0
Music Therapist	N/A	0.5
Total Direct Patient Care Positions	**N/A**	**8.3**

B. Non-Patient Care Positions		
Administrator	N/A	1.0
Office Assistant	N/A	1.0
Bereavement Coordinator	N/A	1.0
Hospice Representative	N/A	1.0
Total Non-Patient Care Positions	N/A	**4.0**
Total Employees *(A+B)*	N/A	
C. Contractual Staff		0.2 Medical Director
Total Staff *(A+B+C)*	**N/A**	**12.5**

Projected FTEs represent average in year 1 but may differ month-to-month due to census ramp-up. The Applicant will employ 12.3 Full-Time Equivalents (FTEs) in Year 1 of which 8.3 will be direct patient care staff. Direct patient care FTEs include a director of nursing, on-call nurse, 2 RNs, 1.8 hospice aides, 1 social worker, 1 chaplain and a part-time music therapist. In addition to the direct patient care and non-patient care FTEs, Heritage Hospice will have a medical director via contract service.

The proposed hospice agency's staffing schedule related to non-clinical staff for the first year of operation was developed from leadership's experience in operating hospice agencies. The proposed hospice agency's staffing schedule related to all clinical staff and the remaining non-clinical staff for the first year of operation was derived from its expected ratios for visits per patient by discipline.

DEVELOPMENT SCHEDULE

TCA §68-11-1609(c) provides that activity authorized by a Certificate of Need is valid for a period not to exceed three (3) years (for hospital and nursing home projects) or two (2) years (for all other projects) from the date of its issuance and after such time authorization expires; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificate of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A certificate of Need authorization which has been extended shall expire at the end of the extended time period. The decision whether to grant an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

- Complete the Project Completion Forecast Chart below. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.
- If the CON is granted and the project cannot be completed within the standard completion time period (3 years for hospital and nursing home projects and 2 years for all others), please document why an extended period should be approved and document the "good cause" for such an extension.

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HFC action on the date listed in Item 1 below, indicate the number of days from the HFC decision date to each phase of the completion forecast.

Phase	**Days Required**	**Anticipated Date (Month/Year)**
1. Initial HFC Decision Date	--	August 23, 2023
2. Building Construction Commenced	n/a	n/a
3. Construction 100% Complete (Approval for Occupancy)	n/a	n/a
4. Issuance of License	130 days	January 2024
5. Issuance of Service	130 days	January 2024
6. Final Project Report Form Submitted (Form HR0055)	190 days	March 2024

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Hamilton

Tywanna Hamilton, being first duly sworn, says that he/she is the applicant named in this application or his/her lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Tennessee Health Facilities Commission and T.C.A. § 68-11-1601, *et seq.*, and that the responses to questions in this application or any other questions deemed appropriate by the Tennessee Health Facilities Commission are true and complete.

Tywanna Hamilton, CEO

Signature/Title

Sworn to and subscribed before me this the 27th day of June, 2023, a Notary Public in and for the County of Hamilton, State of Tennessee.

Tennessee

Adala Boyd

NOTARY PUBLIC

My Commission expires ________________.

MY COMMISSION EXPIRES
SEPTEMBER 16, 2026

ADALA BOYD

HF-0056
Revised 7/02 - All forms prior to this date are obsolete

HERITAGE HOSPICE AND PALLIATIVE CARE LLC - ATTACHMENT INDEX

ATTACHMENT	DESCRIPTION
Attachment 3A	Proof of Publication
Attachment 7A	Articles of Organization Certificate of Existence Filing Information Organizational Chart
Attachment 9A	Lease Warranty Deed Evidencing Landlord Ownership
Attachment 10A	Floor Plan
Attachment 11A	Public Transportation Routes
Attachment 1N	Service Specific Standards and Criteria - Hospice (Attached Separately)
Attachment 1N-2	Letters of Support
Attachment 1N-5	Charity Care Policy
Attachment 1N-6	Leadership Resume Quality Assessment and Performance Improvement Plan Policy and Procedures: Admission Process Initial/Comprehensive Assessment Intake Process Scope of Services Coordination of Care/Service Interdisciplinary Team (IDT) Meeting Interdisciplinary Team Plan of Care Nursing Services Spiritual Services Bereavement Services Admission Guidelines for Inpatient Services Admission for Respite Care Continuous Care Services Improving Organizational Performance
Attachment 1N-17	Restated TDOH Table with Corrections to McMinn and Marion Counties
Attachment 2N	Service Area Map
Attachment 4N	Racial and Ethnic Difference in End of Life Care in the United States Racially Associated Disparities in Hospice and Palliative Care Access Evaluation of Racial Disparities in Hospice Use and End of Life Treatment Intensity Racial Differences in Hospice Use and End of Life Care Preferences Racial and Ethnic Differences in Hospice Use and Hospitalizations at End of Life Among Medicare Beneficiaries with Dementia 2022 Hospice Information Gathering Report, Health Equity in the Hospice Setting The Desires of their Hearts: The Multidisciplinary Perspectives of African Americans on End of Life Care in the African American Community The African-American Spiritual and Ethical Guide to End of Life Care
Attachment 5N	Licensed Hospice Agencies, 2022, TN Department of Health
Attachment 1C	Sample Hospice Service Contracts: General Inpatient and Respite Care
Supplemental Attachment	Hospice Agency Form

ATTACHMENT 3A

Proof of Publication

Form **v1.21**

Chattanooga Times Free Press

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AFFIDAVIT • STATE OF TENNESSEE • HAMILTON COUNTY

Before me personally appeared Samara Swafford, who being duly sworn that she is the Legal Sales Representative of the CHATTANOOGA TIMES FREE PRESS, and that the Legal Ad of which the attached is a true copy, has been published in the above named newspaper and on the corresponding newspaper website on the following dates, to-wit:

TFP Times Free Press 06/15/23; TFP TimesFreePress.com 06/15/23

And that there is due or has been paid the CHATTANOOGA TIMES FREE PRESS for publication the sum of $239.32. (Includes $0.00 Affidavit Charge).

Samara Swafford

Sworn to and subscribed before me this date:15th day of June, 2023

Sheniqua Hambrick

My Commission Expires 12/14/2026

SHENIQUA HAMBRICK
MY COMMISSION EXPIRES DECEMBER 14, 2026

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GENERAL HELP WANTED

FULL-TIME DISPATCHERS
The City of Soddy-Daisy is accepting applications for full-time dispatchers. Applicants shall have a high school diploma or equivalent, be a minimum of 18 years of age, pass a criminal background check, pass a drug screen and must have adequate computer skills. NCIC Certification preferred. The salary range is $37,378 to $47,593. Interested persons may obtain applications at the Soddy-Daisy Municipal Building, 9835 Dayton Pike, accepting applications through June 23, 2023. EQUAL OPPORTUNITY EMPLOYER

ANTIQUES

OLDE TOWNE ANTIQUES:
Going Out Of Business Sale! Huge sale all merchandise, furniture, Fine Jewelry, Glassware, Home Décor, store fixtures, cash register, jewelry cases Etc. Cash, credit/debit cards only. No Checks please. 40% to 50% off on all merchandise. Get a bargain today!
Sale begins Thursday June 15, 2023 and ad Will run until end of sale. 3973 Hixson Pike, 37415. (423) 886-1911
11 am till 6.00 pm Tues thru Saturday.

APPLIANCES

WANTED DEAD OR ALIVE: Washers & Dryers Only. Will pick up and pay cash award. Call 423-624-6654.

FURNITURE

DINING TABLE: Round Pedestal Mahogany in color, seats up to 6 people, also an extension if you need more room. $300. 423-629-0404.

GARAGE/YARD SALES

CHATT., 1145 S Seminole Dr., New and vintage jewelry, kids/adult books, kitchenware, small furn., Barbies, and more. Thurs. Fr. & Sat. June 15-17, 8-4.

CHATT. 5222 Mellon Dr. TOOL SALE! Saturday, June 17th, 8am.

CLEVELAND - 776 Crabapple Lane SE, Fri. & Sat. 8-3. Antiques and collectibles.

MISCELLANEOUS

HERE'S THE BEEF: Barton Creek Farms. Farm Raised Beef Ready for the freezer. Grass or grain fed. See me at the Chatt. Market every Sunday. Call 931-224-6122.

MEETINGS/HEARINGS

LEGAL NOTICE

The Hamilton County Construction Board of Appeals will hold their monthly meeting on Friday, June 30, 2023, at 10:00 a.m. at the Public Works Building, 4006 Cromwell Road. At this time the following applications will be considered for Fire Code Variance. For questions please contact Sherry Moore, Building Commission 209-7860.

MAP Engineers, LLC c/o Michael A. Price
1700 Ooltewah Ringgold Road

MEETING NOTICE

The Board of Zoning Appeals meeting will be held on Wednesday, July 5, 2023 at 10:00 a.m., in the Development Resource Center at 1250 Market Street, Conference Room 1-A.

BOZA-23-23 - 2704 E. 36th Street - Setback Variance
BOZA-23-25 - 5468 Old Hixson Pike - Special Permit for Commercial Parking in an O-1 zone
BOZA-23-29 - 3601 Alton Park Boulevard - Setback Variance
BOZA-23-31 - 1713 Gray Road - Relief from Sec. 38-502 - Accessory Structure in the Front Yard
BOZA-23-32 - 1704 Golf Street - Setback Variance
BOZA-23-33 - 3820 Longview Avenue - Setback Variance
BOZA-23-34 - 1101 Kinsey Drive - Landscape Variance
BOZA-23-35 - 1144 Hurricane Creek Road - Setback Variance
BOZA-23-36 - 5771 Brainerd Road - Relief from the Brainerd Overlay Requirements

If you have any questions concerning this meeting, please call Dottie Cannon at (423) 643-5883.

LEGAL NOTICES

DBE SOLICITATION

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NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Facilities Commission and all interested parties, in accordance with T.C.A. §68-11-1601 et seq., and the Rules of the Health Facilities Commission, that Heritage Hospice and Palliative Care LLC, a newly formed hospice agency with an ownership type of limited liability company, which is solely owned by Tewanna Hamilton, intends to file an application for a Certificate of Need for the establishment of a new home care organization and the initiation of in-home hospice services in Bledsoe, Bradley, Grundy, Hamilton, Marion, McMinn, Meigs, Monroe, Polk, Rhea and Sequatchie Counties, which will be self-managed.

The address of the hospice agency's office will be 2120 Northgate Park Lane, Suite [illegible], Chattanooga, Tennessee 37415 (Hamilton County) and the total project cost is approximated to be $429,000.00.

The anticipated date of filing the application is on or before July 1, 2023.

The contact person for this project is Michael D. Brent, who may be reached at Bradley Arant Boult Cummings, LLP, 1600 Division Street, Suite 700, Nashville, Tennessee 37203 (615) 252-2361 (mbrent@bradley.com).

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for a hearing should be sent to:

Health Facilities Commission
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. §68-11-1607 (c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Facilities Commission no later than fifteen (15) days before the regularly scheduled Health Facilities Commission meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Facilities Commission at or prior to the consideration of the application by the Commission, or may appear in person to express opposition.

[illegible]

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BRADLEY ARANT BOULT CUMMINGS
1600 DIVISION STREET STE 700

NASHVILLE, TN 37203

State of Wisconsin }

County of Brown }

Before me, the undersigned, a Notary Public in and for said county,this d personally came said legal clerk first duly sworn, according to law, says that he/she is a duly authorized representative of *The Knoxville News-Sentinel*, a daily newspaper published at Knoxville, in said county and state, and that the advertisement of

(The Above-Referenced)

of which the annexed is a copy, was published in said paper in the issues dated:

06/15/2023

and that the statement of account herewith is correct to the best of his/he knowledge, information, and belief

Legal Clerk

Subscribed and sworn to before me this June 15 2023

Nancy Heyrman
Notary Public

5·15·27
My commission expires

Publication Cost: $213.04
Ad No: 0005736499
Customer No: 1314916

\# of Affidavits 1
This is not an invoice

NANCY HEYRMAN
Notary Public
State of Wisconsin

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White 1996 Dodge b2500 base camper van
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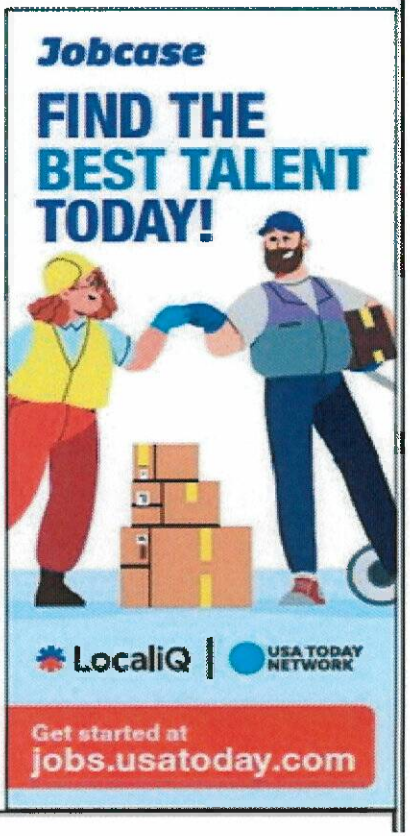
all parties holding interest in the vehicle to contact me by certified mail at 4312 Greenway Dr, Knoxville, TN 37918



ATTACHMENT 7A

Articles of Organization

001420585

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY

SS-4270

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
(minimum fee = $300.00, maximum fee = $3,000.00)

Tre Hargett
Secretary of State

For Office Use Only
-FILED-
Control # 001420585

B1385-3355 04/27/2023 8:29 AM Received by Tennessee Secretary of State Tre Hargett

The Articles of Organization presented herein are adopted in accordance with the provisions of the Tennessee Revised Limited Liability Company Act.

1. The name of the Limited Liability Company is: HERITAGE HOSPICE AND PALLIATIVE CARE LLC

(Note: Pursuant to the provisions of T.C.A. §48-249-106, each Limited Liability Company name must contain the words "Limited Liability Company" or the abbreviation "LLC" or "L.L.C.")

2. Name Consent: (Written Consent for Use of Indistinguishable Name)
☐ This entity name already exists in Tennessee and has received name consent from the existing entity.

3. This company has the additional designation of: None

4. The name and complete address of the Limited Liability Company's initial registered agent and office located in the state of Tennessee is:

TYWANNA HAMILTON
2120 NORTHGATE PARK LANE SUITE 303
CHATTANOOGA, TN 37415
HAMILTON COUNTY

5. Fiscal Year Close Month: December

6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is:
(none) (Not to exceed 90 days)

7. The Limited Liability Company will be:
☐ Member Managed ☑ Manager Managed ☐ Director Managed

8. Number of Members at the date of filing: 1

9. Period of Duration: Perpetual

10. The complete address of the Limited Liability Company's principal executive office is:

14002 CYPRESS CT
ALPHARETTA, GA 30005

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY

SS-4270

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
(615) 741-2286

Tre Hargett
Secretary of State

Filing Fee: $50.00 per member
(minimum fee = $300.00, maximum fee = $3,000.00)

For Office Use Only

-FILED-

Control # 001420585

The name of the Limited Liability Company is: HERITAGE HOSPICE AND PALLIATIVE CARE LLC

11. The complete mailing address of the entity (if different from the principal office) is:

14002 CYPRESS CT
ALPHARETTA, GA 30005

12. Non-Profit LLC (required only if the Additional Designation of "Non-Profit LLC" is entered in section 3.)

☐ I certify that this entity is a Non-Profit LLC whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in T.C.A. §67-4-2004. The business is disregarded as an entity for federal income tax purposes.

13. Professional LLC (required only if the Additional Designation of "Professional LLC" is entered in section 3.)

☐ I certify that this PLLC has one or more qualified persons as members and no disqualified persons as members or holders.

Licensed Profession:

14. Series LLC (optional)

☐ I certify that this entity meets the requirements of T.C.A. §48-249-309(a) & (b)

15. Obligated Member Entity (list of obligated members and signatures must be attached)

☐ This entity will be registered as an Obligated Member Entity (OME) Effective Date: (none)

☐ I understand that by statute: THE EXECUTION AND FILING OF THIS DOCUMENT WILL CAUSE THE MEMBER(S) TO BE PERSONALLY LIABLE FOR THE DEBTS, OBLIGATIONS AND LIABILITIES OF THE LIMITED LIABILITY COMPANY TO THE SAME EXTENT AS A GENERAL PARTNER OF A GENERAL PARTNERSHIP. CONSULT YOUR ATTORNEY.

16. This entity is prohibited from doing business in Tennessee:

☐ This entity, while being formed under Tennessee law, is prohibited from engaging in business in Tennessee.

17. Other Provisions:

Electronic	
Signature	Title/Signer's Capacity
Tywanna Hamilton	Apr 27, 2023 8:29AM
Printed Name	Date

Certificate of Existence

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

HERITAGE HOSPICE AND PALLIATIVE CARE LLC
2120 NORTHGATE PARK LANE
CHATTANOOGA, TN 37415

June 14, 2023

Request Type: Certificate of Existence/Authorization
Request #: 0534318

Issuance Date: 06/14/2023
Copies Requested: 1

Document Receipt

Receipt # : 008178201	Filing Fee:	$20.00
Payment-Credit Card - State Payment Center - CC #: 3852915949		$20.00

Regarding: **HERITAGE HOSPICE AND PALLIATIVE CARE LLC**

Filing Type:	Limited Liability Company - Domestic	Control # :	1420585
Formation/Qualification Date:	04/27/2023	Date Formed:	04/27/2023
Status:	Active	Formation Locale:	TENNESSEE
Duration Term:	Perpetual	Inactive Date:	
Business County:			

CERTIFICATE OF EXISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

HERITAGE HOSPICE AND PALLIATIVE CARE LLC

* is a Limited Liability Company duly formed under the law of this State with a date of incorporation and duration as given above;

* has paid all fees, interest, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

* has appointed a registered agent and registered office in this State;

* has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett

Tre Hargett
Secretary of State

Processed By: Cert Web User

Verification #: 061201515

Filing Information

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Filing Information

Name: **HERITAGE HOSPICE AND PALLIATIVE CARE LLC**

General Information

SOS Control #	**001420585**	Formation Locale:	TENNESSEE
Filing Type:	Limited Liability Company - Domestic 04/27/2023 8:29 AM	Date Formed:	04/27/2023
Status:	Active	Fiscal Year Close	12
Duration Term:	Perpetual	Member Count:	1
Managed By:	Manager Managed		

Registered Agent Address
TYWANNA HAMILTON
2120 NORTHGATE PARK LANE SUITE 303
CHATTANOOGA, TN 37415

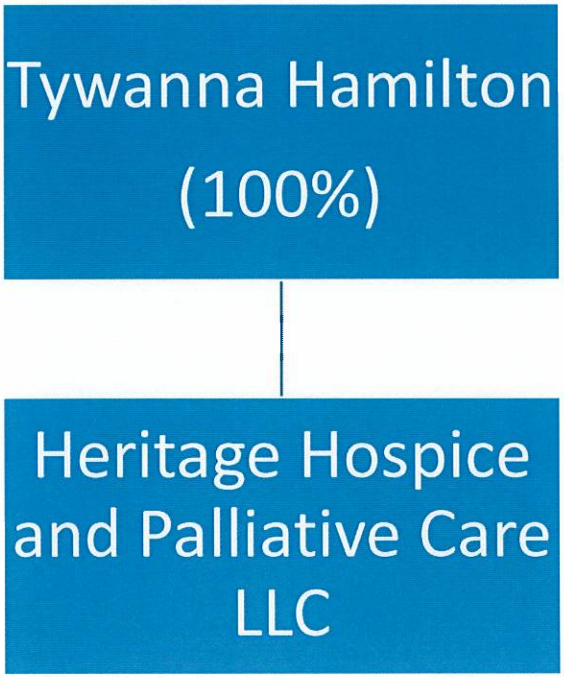
Principal Address
14002 CYPRESS CT
ALPHARETTA, GA 30005

The following document(s) was/were filed in this office on the date(s) indicated below:

Date Filed	**Filing Description**	**Image #**
04/27/2023	Initial Filing	B1385-3355

Active Assumed Names (if any)	**Date**	**Expires**

Organizational Chart



Tywanna Hamilton

(100%)

Heritage Hospice and Palliative Care LLC

ATTACHMENT 9A

Lease

OFFICE LEASE

between:

Hickory Grove Community, LLC

DBA Northgate Park I

and

Tenant:

Heritage Hospice and Palliative Care LLC

Revised 1/1/2021

TABLE OF CONTENTS

OFFICE LEASE

THIS OFFICE LEASE (the "Lease") is entered into as of this ______ day of __April__, 2023____ (the "Effective Date"), by and between ___Hickory Grove Community, LLC dba Northgate Park I___, a Tennessee Limited Liability Company (the "Landlord"), and ___Heritage Hospice and Palliative care LLC___, (the "Tenant").

WITNESSETH:

In consideration of the obligation of Tenant to pay rent as herein provided, and in consideration of the other terms, covenants and conditions hereof, Landlord hereby leases to Tenant, and Tenant hereby leases from Landlord, certain commercial office premises (the "Premises") part of the office building known as ______Northgate Park 1______ (the "Building"), 2120 Northgate Park Lane, Chattanooga, Tennessee, consisting of 2,257 rentable square feet, allocated on the 3rd floor outlined on the floor plan attached hereto as Exhibit A (the Premises) (said property, together with the Building and all other improvements thereon being called the Property), for the term, the rent, and subject to the conditions and covenants hereinafter provided.

Landlord leases office space in the Building based upon a gross base annual rental rate per rentable square foot calculated in accordance with the standards defined by BOMA, the "Standard Method for Measuring Floor Area in Office Buildings", August 1990.

1. FUNDAMENTAL LEASE PROVISIONS AND EXHIBITS.

A. Fundamental Lease Provisions.

(1) Address of Tenant's Premises in the Building:	2120 Northgate Park Lane, Ste 303 Chattanooga, TN 37415
(2) Approximate square feet of Premises:	Two thousand two hundred fifty-seven (2,257).
(3) Commencement Date:	June 1, (2023)
(4) Expiration Date:	The last day of that certain month which is Thirty-six (36) months after Government Approvals as discussed in A.(11).
(5) Term:	The period of time commencing on the Commencement Date and expiring on the Expiration Date.
(6) Lease Year:	Each and every successive twelve-month period during the Term of this Lease; provided, however, that the first Lease Year shall be deemed to commence on the first day of the month in which the Commencement Date occurs. The last Lease Year shall end on the Expiration Date.
(7) Base Rent:	Forty thousand six hundred twenty-six and 00 /100 Dollars ($ 40,626.00) per annum for the first Lease Year, and in the second and subsequent Lease Years in accord with the terms of

Paragraph 4.A. set forth below, payable in monthly installments in accord with the terms of Paragraph 4.A. set forth below.

	Base Rent	Monthly
Months 1-12	$ 40,626.00	$ 3,385.50
Months 13-24	41,844.00	3,487.00
Months 25-36	43,104.00	3,592.00

Included in Base Rent are Utilities of $2.52 per square foot and Real Estate Taxes of $1.48 per square foot. If during the lease period, Utilities and Real Estate Taxes increase per square foot, Tenant is responsible for his pro-rata share of the increases.

(9) Security Deposit: Three thousand three hundred eighty-five and 50 /100 Dollars ($ 3,385.50).

(10) Tenant's Permitted Use of Premises: For general office purposes only.

(11) Tenant's Conditions Precedent. Notwithstanding anything contained in this Lease to the contrary, Tenant's obligation to accept Landlord's tender of the Premises under this Lease is specifically contingent on Tenant receiving a Certificate of Need issued by HSDA for Tenant's intended use of the Premises ("Governmental Approvals"). Tenant shall apply for all Governmental Approvals within ~~ten (10)~~ days of the Effective Date and diligently pursue the issuance of the same. If, following the application for all Governmental Approvals in a timely manner, Tenant does not obtain all such Governmental Approvals, Tenant may, upon written notice to Landlord given at any time within one hundred twenty (120) days of the Effective Date, terminate this Lease, and upon such termination, neither party shall have any liability hereunder except to the extent otherwise expressly provided in this Lease. If Tenant fails to provide notice of termination in a timely manner or otherwise provides notice of its waiver or the satisfaction of such conditions, such conditions shall be deemed satisfied and Tenant's right to terminate under this Section A(11) shall expire. Tenant shall be solely responsible for obtaining all Governmental Approvals at its sole cost.

60 days
T.H.
RN

B. Exhibits.

The Exhibits listed in this paragraph and attached to this Lease are incorporated in this Lease by this reference and are to be construed as part of this Lease. Landlord and Tenant each agree to perform all of their respective obligations stated therein.

Exhibit "A": Floor Plan(s) of Premises;
Exhibit "B": Description of Landlord's Work;
Exhibit "C": Rules and Regulations;
Exhibit "D": Moving Policy;

2. PREMISES.

A. Premises Demised.

Landlord hereby leases to Tenant and Tenant hereby leases from Landlord the Premises, as shown and depicted in the floor plan(s) contained in Exhibit "A," which Premises are located within the Building together with the right to use in common with other tenants of the Building, the "Common Areas" (as defined in Paragraph 8 below).

3. TERM.

The Term of this Lease shall commence on the Commencement Date and expire on the Expiration Date.

4. RENT.

A. Base Rent.

This Lease is made at and for an initial Base Rent in the amount of Forty thousand six hundred twenty-six Dollars ($ 40,626.00) per annum, during the first Lease Year, payable in advance, on or before the first day of each month, in monthly installments of Three thousand three hundred eighty-five and 50/100 Dollars ($ 3,385.50) each during such period. Payment of the first monthly installment of Base Rent due for the first full month during the first Lease Year shall be paid by Tenant in advance upon execution and delivery of this Lease from Tenant to Landlord. Commencing with the second Lease Year, Base Rent shall be payable in advance in the amounts specified below for the Lease Years indicated (said Base Rent, and all additional rent and other sums due and payable by Tenant to Landlord hereunder, are collectively referred to herein as "Rent"). All Rent shall be paid to Landlord without demand, deduction, offset, abatement or diminution at the following address, 2158 Northgate Park Lane, Ste 199, Chattanooga, TN 37415 or at such other location as Landlord may designate from time to time, by written notice to Tenant. In the event that the Commencement Date shall fall on a date other than the first day of a month, the Rent due for such month shall be pro-rated, and the Rent due for the portion of the month between the Commencement Date and the end of such month shall be due and payable in advance on the Commencement Date. It is agreed that beginning with the second Lease Year during the Term hereof, and for each subsequent Lease Year, the Base Rent payable hereunder shall be increased effective as of the first (1st) month of each Lease Year, as follows:

(1) second Lease Year: Forty-one thousand eight hundred forty-four Dollars ($ 41,844.00) per annum, payable in installments of Three thousand four hundred eighty-seven Dollars ($ 3,487.00) per month;

(2) third Lease Year: Forty-three thousand one hundred four Dollars ($ 43,104.00) per annum, payable in installments of Three thousand five hundred ninety-two Dollars ($ 3,592.00) per month;

B. Security Deposit.

The Security Deposit (the "Deposit") shall be held by Landlord as security for the faithful performance and observance by Tenant of all of the agreements, covenants, conditions and provisions of this Lease to be performed or observed by Tenant. Tenant shall not be entitled to any interest, if any, earned thereon, and Landlord may commingle the Deposit with its general funds. In the event Tenant fails to perform or observe any of the agreements, covenants, conditions and provisions of this Lease to be performed or observed by it, then, at Landlord's option, Landlord may, but shall not be obligated to, apply the Deposit, or so much thereof as may be necessary, to remedy any such failure by Tenant. Tenant shall, within five (5) days of receipt of notice from Landlord of such application, pay to Landlord any sum necessary to restore the Deposit to the full amount specified in Paragraph 1 of this Lease. Any remaining portion of the Deposit shall be returned to Tenant within sixty (60) days after the expiration or earlier termination of this Lease, provided that all amounts owed by Tenant to Landlord have been paid in full and Tenant is not then in default hereunder.

C. Late Charges.

In the event that Landlord elects to accept a payment of Rent which is not received by Landlord on or before its due date, Tenant shall pay to Landlord a late charge of five percent (5%) of such payment, or Fifty Dollars ($50.00), whichever is greater, in order to compensate Landlord for its administrative expenses in processing late payments; however, nothing contained herein shall be deemed to require Landlord to accept any payment of Rent received by Landlord after the due date. In addition, Tenant shall pay to Landlord a processing and handling fee of Fifty Dollars ($50.00) for any check of Tenant's which is returned to Landlord because of insufficient funds, as liquidated damages to compensate Landlord for its additional administrative costs and expenses in handling such items, it being agreed that the exact amount thereof would be difficult or impossible to ascertain.

D. Interest.

Any amount due from Tenant to Landlord hereunder which is not paid when due shall bear interest at the rate of eighteen percent (18%) per annum from the due date until paid (but in no event at a rate greater than the maximum rate allowed by law on such obligation), unless otherwise specifically provided herein, but the payment of such interest shall not excuse or cure any default by Tenant under this Lease.

5. IMPROVEMENT OF THE PREMISES.

Landlord shall, at an initial cost to Landlord, construct those improvements to the Premises set forth on Exhibit "B" (the "Landlord's Work"). Unless Tenant shall have given Landlord written notice, within the first full calendar month after the Commencement Date, of any matters which Tenant contends Landlord has not performed pursuant to its obligations under Exhibit "B," Tenant shall have no claim that Landlord has failed to perform any of Landlord's obligations under Exhibit "B," and Tenant shall conclusively be deemed to have accepted the Premises "as is," in their then existing condition.

6. USE OF PREMISES.

Tenant shall not abandon or vacate the Premises during the Lease Term. Tenant agrees to use the Premises in a careful, safe and proper manner, and to comply, at Tenant's sole cost and expense, with all applicable federal, state, county, municipal or other governmental laws, codes, rules and regulations. Tenant further agrees not to use or permit the Premises to be used for any purpose which is inconsistent with Tenant's permitted use of the Premises as specified in Paragraph 1 of this Lease; which is prohibited by applicable law; which is prohibited by or will increase the existing rate or cause cancellation of any of Landlord's insurance policies for the Project; which will in any way obstruct or interfere with the rights of other tenants of the Project, or injure or annoy them; or use or allow the Premises to be used for lodging or for any immoral or objectionable purpose; or bring into the Building any furniture, equipment, materials or other objects which will overload the Building, its structure or any portion thereof, or any electrical or mechanical systems thereof. Tenant shall not commit waste, or permit any waste or any nuisances on or in the Premises.

7. QUIET ENJOYMENT.

Landlord covenants and agrees to warrant and defend Tenant in the quiet enjoyment of the Premises against the claims of all parties claiming by, through or under the Landlord during the Term of this Lease.

8. COMMON AREAS.

A. Common Areas.

Landlord hereby grants to Tenant the non-exclusive right, in common with Landlord and others granted such right by Landlord, to use all the Common Areas within or about the building. The term "Common Areas" as used in this Lease shall include, but not be limited to, parking areas, driveways, truck and delivery passages, truck loading areas, lobbies, entrances, exits, stairs, corridors, elevators, rest rooms, sidewalks and coverings therefore, drainage and retention facilities, and landscaped and planted areas. Landlord hereby also reserves the right to designate and redesignate areas for employee parking, and Tenant agrees to cause all of its personnel to utilize the same.

B. Construction of Additional Improvements.

Landlord may, at its sole option at any time, and from time to time, do any one or more of the following with respect to land, buildings, improvements and/or the Common Areas which are now, or which hereafter become, a part of the Project: (i) construct alterations therein; (ii) construct additions or modifications thereto, or otherwise add thereto or remove therefrom; (iii) construct additional buildings, freestanding or connected to then-existing buildings; (iv) construct deck or elevated parking facilities, freestanding or connected to then-existing buildings; or (v) rearrange, build upon or eliminate any Common Areas, buildings or improvements.

9. MAINTENANCE AND REPAIRS.

A. Landlord's Maintenance and Repairs.

Landlord shall maintain and repair the Building including exterior and interior walls, ceiling, glass, floors, sub-floors, roof, foundation, weight-bearing walls, columns, structural portions, and the Common Areas; the electrical, HVAC and mechanical systems of the Premises, plumbing fixtures, interior electrical fixtures, interior doors and all interior finishes including replacement of any of the foregoing to the extent the same cannot be restored to normal use by general maintenance and repairs. Landlord is responsible for light bulbs, HVAC filters, and similar items. Notwithstanding the foregoing, Tenant shall be responsible for any damages to the Building, the Common Areas or the HVAC or mechanical systems caused by any negligent act or omission of or willful misuse by Tenant, its employees, officers, agents, licensees, invitees, visitors, customers, concessionaires, assignees, subtenants, contractors or subcontractors.

B. Landlord's Right of Entry.

Tenant acknowledges and agrees that Landlord may enter the Premises at any time in the event of an emergency, and at any reasonable time as follows: to examine and inspect same; to exhibit same to prospective purchasers; during the last six (6) months of the Term hereof, or at any time Tenant is in breach of this Lease, to exhibit same to prospective tenants; to perform such repairs, alterations or other maintenance as Landlord is obligated to perform hereunder, or as Landlord may deem necessary or proper for the safety, improvement or preservation of the Premises or the Building; or, if Landlord at its sole option so elects to do in accordance with the terms hereof, to perform any obligations of Tenant hereunder which Tenant shall neglect or refuse to make or perform in accordance with Tenant's obligations hereunder. No such entry or acts of Landlord, its agents, servants, employees or contractors shall constitute or be deemed to constitute an actual or constructive eviction of Tenant, nor result in Landlord being liable for any claims or damages, or any offset, deduction, reduction or abatement of Rent. Landlord agrees to use reasonable efforts to minimize the disturbance of or interference with Tenant.

C. Tenant's Maintenance and Repairs.

Except for the repairs Landlord is specifically obligated to make, Tenant covenants and agrees that it shall at all times during the Term of this Lease make any and all repairs to and replacements in the Premises that are necessary or desirable to keep, repair and maintain the Premises in good condition and repair, and in a safe, dry and tenantable condition. If Tenant fails to keep the Premises in good repair and tenantable condition, Landlord can make such repairs as it deems necessary to put the Premises in good and tenantable condition, and Tenant shall be liable to immediately reimburse Landlord for the cost of such repairs as additional Rent hereunder.

10. SERVICES PROVIDED BY LANDLORD.

Provided Tenant shall not be in default under this Lease, Landlord agrees to provide to Tenant the following services:

A. Heating and air-conditioning service ("HVAC") daily on Mondays through Fridays, from 6:00 a.m. to 6:00 p.m., with New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Day and any other national holiday (herein collectively called the "Holidays") excepted.

B. Elevator service daily on Mondays through Fridays, inclusive, with Holidays excepted, from 7:00 a.m. to 6:00 p.m.

C. Electric current for lighting, replacement bulbs for Building standard lighting, and reasonable facilities for furnishing the usual and normal electric power for office space. Landlord shall have the right to prescribe uniform and reasonable charges for bulb replacement services for non-standard lighting. Tenant shall not, without Landlord's prior written consent, use any equipment, including, without limitation, air-conditioning units, electronic data processing machines, punch card machines, or any other machines which use electric current in excess of 110 volts, which will increase the amount of electricity ordinarily furnished for the use of the Premises as general office space or which require clean (or dedicated) circuits or other special distribution circuits;

D. Common use rest rooms and toilets including hot and cold water.

11. FIXTURES.

Tenant may construct and build or install in the Premises, with Landlord's prior written consent during the Term hereof, such fixtures and other equipment of every kind and nature as Tenant may deem necessary or desirable, or both, in connection with the conduct of Tenant's business at the Premises. Landlord's consent shall not be unreasonably withheld. All such fixtures and other equipment installed by or at the expense of Tenant in accordance with the terms of this paragraph, and capable of being removed from the Premises without damaging the Premises, shall remain the property of Tenant. Provided Tenant is not then in material default under Paragraph 20 of this Lease, Tenant shall at its sole cost and expense remove the same, and repair and restore any portion of the Premises affected thereby, at the expiration or earlier termination of the Term hereof.

12. ALTERATIONS TO THE PREMISES.

Tenant shall make no improvements, alterations or additions of any kind, whether structural or non-structural, in or to the Premises without first obtaining Landlord's prior written consent, and Tenant shall pay the cost of all such improvements, alterations and additions. Landlord's consent for such nonstructural alterations, additions, improvements or remodeling shall not be unreasonably withheld. Landlord's consent for any structural alterations, additions, improvements or other remodeling in or to the Premises may be given or withheld in Landlord's sole discretion. All improvements shall, at the option of Landlord, become the property of Landlord, or, if Landlord provides to Tenant a written notice not less than thirty (30) days prior to the expiration of the Term, or on or before the termination of the Term if such termination occurs by reason of Tenant's default, Landlord may elect to require Tenant to restore the Premises to their original condition; in such case, Tenant shall at its own expense remove any alterations, additions or improvements, whether structural or nonstructural, made by or for it, and Tenant shall repair any damage caused by such removal and restore the Premises to their original condition, ordinary wear and tear excepted. Tenant agrees to make any such alterations, additions or improvements in a good, workmanlike manner, in accordance with plans and specifications therefor which have been submitted to and approved by Landlord, and in accordance with all requirements of municipal or other governmental authorities.

13. COVENANT AGAINST LIENS.

No work performed by Tenant in the Premises, whether pursuant to this Lease or otherwise, whether in the nature of erection, construction, alteration, addition, improvement, remodeling or repair, shall be deemed to be for the immediate use and benefit of Landlord, and no mechanic's, materialman's or other lien shall be allowed against the estate of Landlord by reason of any consent given by Landlord to Tenant to improve the Premises. Tenant shall pay promptly all persons furnishing labor or materials with respect to any work performed by Tenant or its contractor on or about the Premises. In the event any mechanic's, materialman's or other liens shall at any time be filed against the Premises or Landlord's estate therein by reason of work, labor, services or materials performed or furnished, or alleged to have been performed or furnished, to Tenant or anyone holding the Premises by, through or under Tenant, Tenant either shall cause the same to be vacated and canceled of record within twenty (20) days after the date of the filing thereof, or if Tenant in good faith determines that such lien should be contested, Tenant shall furnish such security, by surety bond or otherwise, as may be necessary or prescribed by law to release the same as a lien against the Premises, or any portion thereof or interest therein, and to prevent any foreclosure of such lien during the pendency of such contest. If Tenant shall fail to vacate or release such lien in the manner and within the time set forth herein, then, in addition to any other right or remedy of Landlord resulting from such default of Tenant, Landlord may, but shall not be obligated to, vacate or release the same either by paying the amount claimed to be due or by procuring the release of such lien by giving security or in such other manner as may be prescribed by law. Tenant shall repay to Landlord as additional Rent hereunder, within five (5) days of Tenant's receipt of written demand therefor from Landlord, all sums incurred, disbursed or deposited by Landlord pursuant to the foregoing provisions of this paragraph, including Landlord's costs and expenses and reasonable attorneys' fees incurred in connection therewith. Nothing contained in this Lease shall be deemed or construed in any way as constituting the consent or request of Landlord, express or implied, by inference or otherwise, to any contractor, subcontractor, laborer or materialman for the performance of any labor or the furnishing of any materials for any specific improvement, alteration to or repair of the Premises, or any part thereof, nor as giving Tenant a right, power or authority to contract for or permit the rendering of any services or the furnishing of any materials whether as agent of or on behalf of or to the benefit of Landlord or otherwise, nor that would give rise to the filing of any mechanic's, materialman's, laborer's or other liens against Landlord's interest in the Premises or the Project.

14. ASSIGNMENT AND SUBLETTING.

Tenant shall not, without at least thirty (30) days' prior written notice to Landlord, in accord with the Notices provision of this Lease, and the prior written consent of Landlord in each instance, directly or indirectly, voluntarily or involuntarily, by operation of law, merger, consolidation, reorganization or otherwise, mortgage, hypothecate, pledge, encumber, sell, transfer or assign this Lease, in whole or in part; nor sublease all or any part of the Premises; nor permit the use of occupation of all or any part of the

Premises by any other party (all of the foregoing being collectively referred to as an "Assignment"). Such notice of proposed Assignment shall be accompanied by a copy of any and all documents, instruments and agreements pertaining to such transaction. Tenant shall pay Landlord a Five Hundred Dollar ($500.00) application fee for review of the request for consent to an Assignment; in addition, Tenant shall promptly reimburse Landlord for its reasonable attorneys' fees in connection with reviewing any proposed Assignment. Landlord shall have thirty (30) days from its actual receipt of Tenant's notice of proposed Assignment and all other required and requested information within which to elect, in its sole and absolute discretion, to: reject the proposed Assignment and to thereby continue this Lease in full force and effect as if such Assignment had never been proposed; enter into a new lease with the proposed assignee or any other person, on such terms as Landlord and such assignee or other person may agree; or, consent to the proposed Assignment on such terms and conditions as Landlord deems necessary or appropriate. Landlord's consent may be granted or denied in its sole discretion but will not be unreasonably withheld. At a minimum, without limitation, the following requirements shall be satisfied: (a) Tenant shall not be released from obligations or any liabilities hereunder as a result of any such Assignment; (b) Tenant shall not be in default hereunder at the time it requests Landlord's consent or on the effective date of any such Assignment; (c) any Assignment or attempted Assignment without Landlord's consent shall be null and void, and ineffective to transfer any rights or interest to the assignee thereof; (d) Landlord shall have been provided with such information regarding the name, identity, business reputation and creditworthiness of the proposed assignee as Landlord shall request, and shall be satisfied therewith; and (e) the assignee shall deliver to Landlord a written agreement whereby it assumes jointly and severally with Tenant all of the obligations and liabilities of Tenant under this Lease. The following shall also constitute an Assignment for purposes of this paragraph: (a) the sale of a majority of Tenant's assets, including Tenant's inventory if sold out of the normal course of business; or (b) if Tenant is a corporation, the sale or transfer of a majority of Tenant's voting stock; or, (c) if Tenant is a partnership, a sale of (i) the general partner's interest; or (ii) if the general partner is a corporation, a majority of the voting stock of such corporation; or (iii) if the general partner is a partnership, the general partner's interest therein. In the event of an Assignment in violation of the terms of this paragraph, Tenant shall be in default of this Lease. In no event shall Tenant be entitled to any rent, rentals, payment, profit or any other sum or cost of the assignee or sublessee for such Assignment in excess of the then applicable Rent payable by Tenant hereunder. Landlord shall have the sole and absolute right to any and all amounts paid or payable in excess of the Rent payable by Tenant, and Landlord may, at its election, receive same directly from the assignee, or require Tenant to collect and remit same to Landlord as additional Rent hereunder. Landlord's consent in one instance, and any other act or acts of Landlord or its agents, shall not be deemed to constitute consent to any subsequent Assignment. The listing of any name other than that of Tenant on any door of the Premises, or on any Building directory or in any elevator or otherwise, shall not operate as a substitute for or be deemed to constitute the prior written notice to Landlord required under this Paragraph 14, nor shall it vest in the person so named any right or interest in this Lease or the Premises, and it is understood and agreed that any such naming or listing shall constitute a privilege extended by Landlord revocable at any time in its sole and absolute discretion.

15. SIGNS.

Tenant shall obtain the written approval of Landlord prior to placing and maintaining, or causing or permitting to be placed and maintained, any sign, advertising matter or other thing of any kind, on, or which is visible from, the exterior of the Premises. Landlord has the right to remove any signs not approved by it and to recover from Tenant the cost of such removal as additional Rent hereunder.

16. INSURANCE.

A. Insuring Party.

As used in this paragraph, the term "insuring party" shall mean the party who has the obligation to obtain the insurance required hereunder. Where the insuring party is Tenant, Tenant shall pay the cost of such insurance directly; where the insuring party is Landlord, such cost shall be included in the Operating Expenses, unless otherwise provided herein.

B. Landlord's Insurance.

(1) Landlord, as insuring party under this paragraph, shall obtain and keep in force during the Term of this Lease an insurance policy or policies of all-risks fire, extended coverage, theft, vandalism, malicious mischief and other casualty, covering loss or damages to the Project and the Common Areas, as well as all improvements thereto, and the structural improvements to the Premises.

(2) Landlord, as the insuring party under this paragraph, shall also obtain and keep in force during the Term of this Lease such other insurance in such amounts and with such policy provisions as it shall deem necessary or appropriate, including without limitation the following: comprehensive commercial general liability insurance pertaining to the Project and the Common Areas, and personal injuries, death and property damage arising or occurring therein; worker's compensation insurance covering Landlord's personnel; fidelity bonds for Landlord's personnel; insurance against liability for assault and battery, defamation and claims of false arrest; and plate glass insurance for glass exclusively securing the Common Areas or not otherwise payable by particular tenants.

(3) Tenant shall reimburse Landlord for any increase in the cost of any of Landlord's insurance pertaining to the Project if said increase is caused by or results from Tenant's use or occupancy of the Premises, the breach of this Lease by Tenant, or the acts, omissions, or negligence of Tenant, its employees, officers, agents, licensees, invitees, visitors, customers, concessionaires, assignees, subtenants, contractors or subcontractors.

C. Tenant's Insurance.

Tenant shall, at Tenant's sole cost and expense, obtain and maintain in force during the Term of this Lease the following insurance coverage with respect to the insurable losses contemplated by this paragraph, insuring Landlord, Tenant and any lender of record encumbering the Premises:

(1) Extended coverage insurance against fire, and standard "all risk" protection, including but not limited to coverage for sprinkler leakage, vandalism and malicious mischief perils, with replacement cost endorsement on Tenant's improvements in or to the Premises and its personal property, including but not limited to fixtures, furnishings, equipment, furniture, inventory, and stock;

(2) Insurance covering all miscellaneous electrical apparatus and all other insurable objects owned or operated by Tenant or by others (other than Landlord) on behalf of Tenant in the Premises, or relating to or serving the Premises;

(3) Insurance against any liability arising out of the ownership, use, occupancy, operation, or conduct of business from, or maintenance of, the Premises and all areas appurtenant thereto; such insurance shall be in the form of a combined single limit comprehensive commercial general liability insurance policy in an amount of not less than One Million Dollars ($1,000,000.00); shall insure performance by Tenant of the indemnity provisions of this Lease; and, shall contain a broad form general liability endorsement. It is further understood and agreed to by Tenant that Tenant shall increase said insurance coverage as required by Landlord, not more frequently than once each year, if, in the reasonable opinion of Landlord, the amount of liability insurance required hereunder is not adequate; provided, however, that in no event shall the amount of the liability insurance increase by more than fifty percent (50%) greater than the amount thereof during the preceding year of the Term of this Lease;

and, provided further, the failure of Landlord to require additional insurance coverage shall not be deemed to relieve Tenant from any obligations under this Lease;

(4) Business interruption insurance in such amount as will reimburse Tenant for direct or indirect loss of earnings attributable to all such perils insured against and cover Tenant's obligation for the Base Rent and Operating Expenses due Landlord during said interruption; and,

(5) Worker's compensation insurance in the statutorily required amounts covering all Tenant's employees working in the Premises.

D. Procurement of Tenant's Insurance by Landlord.

If Tenant shall fail to procure or maintain any insurance required of Tenant hereunder, Landlord may, at its sole option, but shall not be required to, procure and maintain the same at the cost and expense of Tenant, and Tenant agrees to reimburse Landlord for same as additional Rent due hereunder within fifteen (15) days after receiving notice of the amount thereof from Landlord.

E. Insurance Policies.

The limits of Tenant's insurance shall not limit the liability of Tenant under this Lease. All insurance required hereunder shall be by companies holding a "General Policyholders Rating" of A or better as set forth in the most current issue of "Best's Insurance Guide." The insuring party shall deliver to the other party copies of policies of such insurance or certificates evidencing the existence and amounts of such insurance with loss payable clauses satisfactory to Landlord. No insurance policy of Tenant shall be cancelable, nonrenewed, or subject to reduction of coverage or other modification except after thirty (30) days' prior written notice to Landlord. If Tenant is the insuring party, Tenant shall, within fifteen (15) days prior to the expiration of such policies, furnish Landlord with renewals or "binders" thereof. Tenant shall not do nor permit to be done anything which shall invalidate the insurance policies Tenant is required to maintain under this Lease.

F. Additional Insurance.

Notwithstanding any provisions to the contrary contained in this Lease, the insuring party shall also provide insurance against damage by such other perils as any party holding a "Mortgage" (as defined in Paragraph 28 below) on the Project, including the Premises, may from time to time require.

G. Blanket Policy.

If at any time during the Term of this Lease the insuring party shall have in full force and effect a blanket policy of general liability insurance and/or property insurance as applicable, which complies with the requirements described above applicable to such insuring party, as well as coverage of other premises and properties of the insuring party or in which the insuring party has some interest, such blanket insurance shall satisfy the requirements hereof.

17. INSURABLE HAZARDS; WAIVER OF SUBROGATION.

A. Insurable Hazards; Landlord's Waiver of Subrogation.

Landlord covenants and agrees that Tenant shall not be liable for any damage to the Premises, or any part thereof, if such damage is caused by fire or other hazards insured under the insurance policies of Landlord and/or Tenant, regardless of the cause thereof, and Landlord hereby expressly releases Tenant from liability for any such damage, with such waiver and release from liability to be limited to the extent such loss or damage is covered and paid for by valid and collectible insurance in effect at the time of such loss or damage. Landlord covenants and agrees that all of its insurance policies covering or relating to the Project shall include a clause waiving any and all rights of subrogation against Tenant to the extent of Landlord's waiver and release above.

B. <u>Insurable Hazards; Tenant's Waiver of Subrogation</u>.

Provided that any injury, loss or damage specified in this paragraph is caused by fire or other hazards insured under the policies of Landlord and/or Tenant, Tenant hereby agrees that Landlord shall not be liable for, and Tenant hereby releases Landlord from any liability for, any injury to Tenant's business or any loss of income therefrom, or for damage to the improvements, furniture, equipment or other property of Tenant ("Tenant's Contents"), Tenant's employees, officers, agents, licensees, invitees, visitors, customers, concessionaires, assignees, subtenants, contractors or subcontractors, or any other person in or about the Premises, nor shall Landlord be liable for injury to the person of Tenant, Tenant's employees, officers, agents, licensees, invitees, visitors, customers, concessionaires, assignees, subtenants, contractors or subcontractors, whether such damage or injury is caused by or results from fire, steam, electricity, gas, water or rain, or from the breakage, leakage, obstruction or other defects of pipes, sprinklers, wires, appliances, plumbing, air conditioning or lighting fixtures, or from any other cause; whether the said damage or injury results from conditions arising upon the Premises or upon other portions of the building of which the Premises are a part, or from other sources or places; and regardless of whether the cause of such damage or injury or the means of repairing the same is inaccessible to Tenant. Landlord shall not be liable for any damages arising from any act or neglect of any other tenant, if any, of the Building or Project. Tenant hereby expressly releases Landlord and any lender of record encumbering the Premises from any and all such liability for any such injury or damage, and hereby waives any and all rights of subrogation which any insurers of Tenant have or may have against Landlord or any such lender under any and all policies of insurance pertaining to the Premises, Tenant's Contents and/or Tenant's business.

18. DESTRUCTION OR DAMAGE.

If the Premises shall be damaged or destroyed in whole or in part by fire, casualty or other causes covered by Landlord's Insurance, and Landlord does not elect to terminate this Lease as provided hereinafter, Landlord shall promptly and diligently restore the Premises, to the extent of Landlord's Work therein, to their condition immediately prior to such destruction or damage, provided that, in Landlord's reasonable estimation, such repairs can be made within sixty (60) days of such destruction or damage. Tenant shall, upon substantial completion by Landlord, promptly and diligently and at its sole cost and expense, repair and restore any improvements to the Premises made by Tenant, as well as Tenant's Contents, to the condition thereof prior to such destruction or damage. If, in Landlord's reasonable estimation, the Premises cannot be restored, to the extent of Landlord's Work therein, within sixty (60) days of such damage or destruction, Landlord at its option shall, by written notice to Tenant given within sixty (60) days after the date of such fire or other casualty, either (i) elect to repair or restore such damage, this Lease continuing in full force and effect, or (ii) terminate this Lease as of a date specified in such notice, which date shall not be less than thirty (30) nor more than sixty (60) days after the date such notice is given. Until the restoration of Landlord's Work is complete, Landlord covenants and agrees that there shall be an abatement or reduction of Base Rent in the same proportion that the amount of square feet of the Premises so damaged or destroyed and under restoration bears to the square feet of the Premises, unless the damaging event was caused by the negligence or willful misconduct of Tenant, its employees, officers, agents, licensees, invitees, visitors, customers, concessionaires, assignees, subtenants, contractors or subcontractors, in which event there shall be no such abatement.

Notwithstanding the foregoing provisions of this paragraph, if damage to or destruction of the Premises, in excess of fifty percent (50%) of the value of Landlord's Work, shall occur within the last Lease Year, or within the last year of the Term of this Lease, as the same may be extended as provided hereinafter, the obligation of Landlord to restore Landlord's Work in the Premises shall not arise unless (i) Landlord, at its sole option, elects to restore such work; (ii) Landlord, at its sole option, elects to provide Tenant with the opportunity of extending the Term of this Lease for an additional period so as to expire five (5) years from the date of the completion by Landlord of the repairs and restoration to Landlord's Work; and, (iii) Tenant gives written notice to Landlord within thirty (30) days after Landlord's request that it agrees to such extension. Such extension shall be on the terms and conditions provided herein, if an option to extend this Lease remains to be exercised by Tenant hereunder, or under the terms prescribed in Landlord's notice, if no such further extension period is provided for herein. Upon receipt of such notice from Tenant, Landlord agrees to promptly repair and restore Landlord's Work in the Premises. Failing such notice to extend, Landlord at its option shall have the right to terminate this Lease as of the date of the damaging event, or to restore Landlord's Work in the Premises and the Lease shall continue for the remainder of the then unexpired Term, or until the Lease is otherwise terminated as provided herein. Landlord's obligation to repair or restore the Premises in the event of damage to or destruction of the Premises is subject to the rights of the holder of any "Mortgage" as defined hereinbelow.

19. CONDEMNATION.

If during the Term of this Lease all or more than twenty-five percent (25%) of the square feet of the Premises shall be taken as a result of the exercise of the power of eminent domain, or shall be sold or conveyed by Landlord under threat of the exercise of such power, either Landlord or Tenant may elect to cancel this Lease by written notice to the other given within sixty (60) days after the occurrence of the event. If neither Landlord nor Tenant elects to or has a right to cancel this Lease as aforesaid, Landlord covenants and agrees to restore the Building, Common Areas and Landlord's Work in Premises to their condition prior to any such condemnation, to the extent reasonably possible in light of same. Until the date that restoration of the Premises is substantially complete, the Base Rent due hereunder shall abate in the same proportion that the amount of the square feet of the Premises under restoration bears to the total square feet of the Premises. Tenant shall make any repairs to the Premises other than Landlord's Work and shall repair and restore Tenant's furnishings and equipment as soon as it is reasonably practicable to do so, but in any event within thirty (30) days after the substantial completion of the repair and restoration of Landlord's Work. Any and all awards or proceeds for or from any condemnation of the Premises in whole or in part or conveyance in lieu thereof, and/or of Tenant's interest under this Lease, shall belong to and be the property of Landlord without any participation by Tenant except as follows: Tenant shall have the right to claim, prove and receive a separate award for the unamortized value of its trade fixtures and equipment, and its moving expenses, if any, provided that same shall not reduce the award payable to Landlord. Landlord's and Tenant's rights and obligations hereunder are subject to the rights of the holder of any "Mortgage" as defined herein below.

20. DEFAULT.

A. Events of Default. The occurrence of any of the following shall constitute an event of default hereunder by Tenant:

(1) The Rent payable under this Lease, including any additional Rent, or any other sum of money due hereunder is not paid when due, and such failure to pay continues for more than five (5) days after Tenant's receipt of written notice thereof from Landlord. Provided however, that Landlord shall not be required to provide Tenant with the notice and five-day period set forth in this subparagraph more than one (1) time during any Lease Year during the Term of this Lease, as the same may be extended, and the second and each subsequent failure during such Lease Year to timely pay such sums shall immediately constitute an event of default hereunder without any notice thereof from Landlord;

(2) The Premises are deserted, vacated, or not used as regularly or consistently as would normally be expected for similar premises put to the same or similar purposes as set forth herein, even though the Tenant continues to pay the stipulated Rent, and such condition is not corrected within ten (10) days of Tenant's receipt of written notice thereof from Landlord. Provided however, that Landlord shall not be required to provide Tenant with the notice and ten-day period set forth in this subparagraph more than once during the Term of this Lease, as the same may be extended, and the second and each subsequent occurrence of such condition shall immediately constitute an event of default hereunder;

(3) Tenant files any petition for debt relief under any section or chapter of the national or federal Bankruptcy Code or any other applicable federal or state bankruptcy, insolvency or other similar act;

(4) Any petition is filed against Tenant under any section or chapter of the national or federal Bankruptcy Code or any other applicable federal or state bankruptcy, insolvency or other similar act, and such petition is not dismissed within sixty (60) days after the date of such filing;

(5) Tenant shall become insolvent or transfer property to defraud creditors;

(6) Tenant makes material misrepresentations to Landlord prior to or contemporaneously with the execution of this Lease;

(7) Tenant shall make an assignment for the benefit of creditors;

(8) A receiver is appointed for any of Tenant's assets, and such receiver is not removed within sixty (60) days of Tenant's receipt of notice from Landlord to obtain such removal;

(9) A lien is filed against the Premises or Landlord's estate therein by reason of any work, labor, services or materials performed or furnished, or alleged to have been performed or furnished, to Tenant or anyone holding the Premises by, through or under Tenant, and Tenant fails to cause the same to be vacated and canceled of record, or bonded off in accord with the provisions of this Lease, within twenty (20) days after the filing date thereof; or,

(10) Tenant fails to observe, perform and keep each and every of the covenants, agreements, provisions, stipulations and conditions contained in this Lease to be observed, performed and kept by Tenant, including without limitation the Rules and Regulations, as defined below, for the Project, and, unless otherwise specified herein, Tenant persists in such failure for twenty (20) days after receipt of written notice by Landlord requiring that Tenant correct such failure.

B. Remedies. Upon the occurrence of an event of default, Landlord shall have the option to do and perform any one or more of the following, in addition to, and not in limitation of, any other right or remedy available to Landlord at law or in equity or elsewhere under this Lease:

(1) Terminate this Lease, in which event Tenant shall immediately surrender the Premises to Landlord, but if Tenant shall fail to do so, Landlord may, without further notice and without prejudice to any other remedy Landlord may have for possession or arrearages in Rent, enter upon the Premises and expel or remove Tenant and Tenant's effects, by force if necessary, without being subject to prosecution or liable for any claim for damages therefor; and Tenant agrees to indemnify Landlord for all loss and damage which Landlord may suffer by reason of such termination, whether through inability to relet the Premises, or through decrease in Rent, or otherwise; and/or

(2) Terminate Tenant's right of possession of the Premises without terminating this Lease, and enter the Premises as the agent of Tenant, by force if necessary, without being subject to prosecution or liable for any claim for damages therefor, and relet the Premises as the agent of Tenant without advertisement and by private negotiations and for any term Landlord deems proper, and receive the rent therefor, and Tenant shall pay Landlord upon demand any deficiency that may arise by reason of such reletting, but Tenant shall not be entitled to any surplus funds generated by such reletting. Tenant shall reimburse Landlord for all costs of reletting the Premises including, but not limited to, advertising expenses, commissions, and the cost of improvements reasonably required in order to relet the Premises; and/or

(3) As agent of Tenant, do whatever Tenant is obligated to do by the provisions of this Lease and enter the Premises, by force if necessary, without being subject to prosecution or liable for any claims for damages therefor, in order to accomplish this purpose. Tenant agrees to reimburse Landlord immediately upon demand for any expenses which Landlord may incur in thus effecting compliance with this Lease on behalf of Tenant, and Tenant further agrees that Landlord shall not be liable for any damages resulting to Tenant from such action, whether caused by the negligence of Landlord or otherwise; and/or

(4) In addition to all Rent and other amounts previously due and unpaid under the terms and conditions of the Lease, Landlord shall be entitled to collect as liquidated damages and not as a penalty, the accelerated present value of the Rent, including any other sums treated as additional Rent hereunder, and all other sums provided herein to be paid by Tenant during the remainder of the Lease Term (the "Rent Balance"), less the Net Rental Value of the Premises, as hereinafter defined. The term "Net Rental Value" shall mean the fair rental value of the Premises for the remainder of the Lease Term reduced to present value, less the Landlord's costs, expenses and attorneys' fees in connection with preparation of the Premises for reletting and for the reletting itself; provided however, the parties agree that in no event shall the Net Rental Value exceed the Rent Balance. The parties agree that the damages caused by the Tenant's default would be difficult or impossible to accurately estimate and that this measure of damages is a reasonable pre-estimate of the Landlord's probable loss resulting from Tenant's breach. The acceptance of the liquidated damages set forth in this paragraph shall not constitute a waiver of any failure of Tenant thereafter occurring to comply with any term, provision, condition or covenant of this Lease. The acceptance of such payment by Landlord shall not constitute a waiver of any failure of Tenant thereafter occurring to comply with any term, provision, condition or covenant of this Lease.

(5) If Landlord exercises any of the remedies set forth in this Lease or under Tennessee law, in addition to all other costs and expenses Landlord shall be entitled to recover under this Lease, Landlord shall also be entitled to recover (a) the cost of performing any other covenants which would have otherwise been performed by Tenant; (b) the amount of any rental abatement or other rental concession provided by Landlord to Tenant; provided however, that in no event shall Tenant's liability hereunder exceed the total Rent due under this Lease; (c) all sums expended by Landlord, and not previously reimbursed to Landlord by Tenant, in connection with improving or repairing the Premises to Tenant's specifications; and, (d) all costs and expenses incurred by Landlord in connection with the termination of this Lease and eviction of Tenant.

C. <u>No Waiver</u>. No act or thing done by Landlord or Landlord's agents during the Term shall be deemed an acceptance of a surrender of the Premises, and no agreement to accept a surrender of the Premises shall be valid unless the same be made in writing and executed by Landlord. Any waiver of or redress for any violation of any covenant or condition contained in this Lease, or any of the Rules and Regulations, as defined below, now or hereafter adopted by Landlord, shall not prevent a subsequent act, which would have originally constituted a violation, from having all the force and effect of an original violation.

D. Attorneys' Fees. In case it should be necessary or proper for Landlord to bring any action under this Lease, or to consult, or place this Lease or any amount payable by Tenant hereunder, with an attorney concerning or for the enforcement of any of Landlord's rights hereunder, then Tenant in each and every such case shall pay Landlord its attorneys' fees in the amount of fifteen percent (15%) of all sums due and owing by Tenant.

21. BANKRUPTCY OF TENANT.

Tenant acknowledges that this Lease is a lease of nonresidential real property and therefore agrees that Tenant, as the debtor in possession, or the trustee for Tenant (collectively, the "Trustee") in any proceeding under Title 11 of the United States Bankruptcy Code as amended (the "Bankruptcy Code") relating to bankruptcy, shall not seek or request any extension of time to assume or reject this Lease or to perform any obligations of this Lease which arise from or after the order of relief.

If the Trustee proposes to assume or to assign this Lease or sublet the Premises (or any portion thereof) to any person or entity which shall have made a bona fide offer to accept an assignment of this Lease or a subletting on terms acceptable to the Trustee, then the Trustee shall give written notice to Landlord and lessors and Mortgagees, as defined below, of which Tenant has notice, setting forth the name and address of such person or entity and the terms and conditions of such offer, no later than twenty (20) days after receipt of such offer, but in any event no later than ten (10) days prior to the date on which the Trustee makes application to the Bankruptcy Court for authority and approval to enter into such assumption and assignment or subletting. Landlord shall have the prior right and option, to be exercised by written notice to the Trustee given at any time prior to the effective date of such proposed assignment or subletting, to accept an assignment of this Lease or subletting of the Premises upon the same terms and conditions and for the same consideration, if any, as the bona fide offer made by such person or entity, less any brokerage commissions which may be payable out of the consideration to be paid by such person or entity for the assignment or subletting of this Lease.

The Trustee shall have the right to assume Tenant's rights and obligations under this Lease only if the Trustee (i) promptly cures or provides adequate assurance that the Trustee will promptly cure any default under the Lease; (ii) compensates or provides adequate assurance that the Trustee will promptly compensate Landlord for any actual pecuniary loss incurred by Landlord as a result of Tenant's default under this Lease; and (iii) provides adequate assurance of future performance under the Lease. Adequate assurance of future performance by the proposed assignee or subtenant shall include, as a minimum, that (a) any proposed assignee or subtenant shall deliver to Landlord a security deposit in an amount equal to at least three (3) months' Rent accruing under the Lease; (b) any proposed assignee or subtenant shall provide to Landlord an audited financial statement, dated no later than six (6) months prior to the effective date of such proposed assignment or sublease with no material change therein as of the effective date, which financial statement shall show the proposed assignee or subtenant to have a net worth equal to at least twelve (12) months' Rent accruing under the Lease, or, in the alternative, the proposed assignee or subtenant shall provide a guarantor of such proposed assignee's or subtenant's obligations under the Lease, which guarantor shall provide an audited financial statement meeting the requirements of this subpart and shall execute and deliver to Landlord a guaranty agreement in form and substance acceptable to Landlord; and (c) any proposed assignee or subtenant shall grant to Landlord a security interest in favor of Landlord in all furniture, fixtures, and other personal property to be used by such proposed assignee or subtenant in the Premises. All payments of Rent required of Tenant under this Lease, whether or not expressly denominated as such in this Lease, shall constitute rent for the purposes of Title 11 of the Bankruptcy Code.

The parties agree that for the purposes of the Bankruptcy Code relating to (i) the obligation of the Trustee to provide adequate assurance that the Trustee will "promptly" cure defaults and compensate for actual pecuniary loss, the word "promptly" shall mean that cure of defaults and compensation will occur no later than sixty (60) days following the filing of any motion or application to assume this Lease; and (ii) the obligation of the Trustee to compensate or to provide adequate assurance that the Trustee will promptly compensate Landlord for "actual pecuniary loss" shall mean Landlord's damages upon default, including but not limited to payments of past due Rent, including interest at the rate provided for in Paragraph 4.F., all attorneys' fees, and all related costs and expenses of Landlord incurred in connection with any default of Tenant and in connection with Tenant's bankruptcy proceedings.

Any person or entity to which this Lease is assigned pursuant to the provisions of the Bankruptcy Code shall be deemed, without further act or deed, to have assumed all of the obligations arising under this Lease and each of the conditions and provisions hereof on and after the date of such assignment. Any such assignee shall, upon the request of Landlord, forthwith execute and deliver to Landlord an instrument, in form and substance acceptable to Landlord, confirming such assumption.

22. NOTICES.

A. Methods for Giving Notice.

Any notice or other communication required or permitted to be given under this Lease must be in writing and shall be effectively given or delivered if hand delivered to the addresses for Landlord and Tenant stated below, or if sent by certified United States Mail, return receipt requested, or if sent by receipted overnight delivery service, to said addresses. Notice effected by hand delivery or receipted overnight delivery service shall be deemed to have been received upon the earlier of actual receipt or refusal thereof. Any notice mailed shall be deemed to have been received upon the earlier of (a) actual receipt, (b) refusal thereof, or (c) three (3) days after mailing of same. Either party shall have the right to change its address to which notices shall thereafter be sent and the party to whose attention such notice shall be delivered by giving the other party notice thereof in accordance with the provisions of this paragraph. Until such time as either party shall change its address for notices, notices shall be forwarded as follows:

To Landlord: Attention:
Hickory Grove Community, LLC dba Northgate Park II
2158 Northgate Park Lane, Suite 199
Chattanooga, Tennessee 37415

To Tenant: Attention:
Tywanna Hamilton
14002 Cypress Court
Alpharetta, GA 30005

B. Mortgagee Protection.

In the event that Landlord gives notice to Tenant of the name and address of any holder of a Mortgage, as such term is defined in Paragraph 28 hereof (such holder being herein referred to as a "Mortgagee"), Tenant agrees to send to any such Mortgagee, by certified mail, a copy of any notice of default given by Tenant to Landlord. Tenant further agrees that if such default is not cured by Landlord, the Mortgagee shall be allowed thirty (30) days in which to cure the default or, if the default cannot be cured within the thirty-day period, to begin diligently pursuing such cure.

23. SURRENDER OF PREMISES.

Upon the expiration or other termination of the Term of this Lease, as the same may have been extended, Tenant shall promptly quit and surrender to Landlord the Premises, together with all improvements belonging to Landlord, free of debris, broom clean, ordinary wear and tear excepted, and Tenant shall remove all of its personal property required or permitted to be removed hereunder. All such property not promptly removed by Tenant shall be deemed abandoned by Tenant, and title to the same shall pass to Landlord under this Lease as by a bill of sale. Provided however, that Tenant shall not be permitted to remove any movable furniture, personal property, or equipment from the Premises at any time, including at the end of the Term or any renewal thereof or other sooner termination of this Lease, if Tenant is then in material default under Paragraph 20 of this Lease.

24. RENEWAL OF LEASE.

Notwithstanding anything to the contrary contained in the Lease, the term of this Lease shall be extended for two (2) additional one-year options at a 3% increase per option. Such notice must be provided at least 60 days prior to the end of the then current term.

25. NO WAIVER OF RIGHTS.

No waiver of any condition or covenant of this Lease by either party shall be deemed to imply or to constitute a further waiver of the same or any other condition or covenant of this Lease. No failure to or delay in exercise of any right or power given herein, or to insist upon strict compliance with any obligation herein, and no custom or practice of either party at variance with any term hereof, shall constitute a waiver or modification of the terms hereof by either party or any right to demand strict compliance with the terms hereof. No officer, agent or employee of Landlord has or shall have any authority to waive any provision of this Lease unless such waiver is expressly made in writing and signed by an authorized officer of Landlord.

26. INDEMNIFICATION AND HOLD HARMLESS.

Tenant covenants and agrees to hold and save Landlord harmless from and to indemnify Landlord against any and all claims, injury, loss or damage, costs or expenses, including, without limitation, court costs and reasonable attorneys' fees, of whatever nature, to any person or property within the Premises or the Project which is not due solely to the gross negligence or willful misconduct of Landlord or its agents and which arises out of Tenant's use of the Premises, or which is caused by or results from the negligence or misconduct, or breach of this Lease, of or by Tenant, its employees, officers, agents, licensees, invitees, visitors, customers, concessionaires, assignees, subtenants, contractors or subcontractors. Tenant, upon notice from Landlord of any claim or any action or proceeding brought thereon, shall defend the same at Tenant's expense by counsel satisfactory to Landlord. Tenant hereby assumes all risks of damages to property or injury to person in, upon or about the Premises arising from any cause, other than the gross negligence or willful misconduct of Landlord or its agents, and Tenant hereby waives, to the full extent permitted by law, all claims in respect thereof against Landlord.

27. EXCULPATION OF LANDLORD.

Landlord's obligations and liability to Tenant with respect to this Lease shall be limited solely to Landlord's interest in the Project, and neither Landlord nor any joint venturers (if any), partners, officers, directors, employees or shareholders of or in Landlord shall have any personal liability whatsoever with respect to this Lease.

28. SUBORDINATION AND ATTORNMENT.

This Lease and all rights of Tenant hereunder are and shall be subject and subordinate to any mortgage, deed to secure debt, deed of trust, ground lease or other instrument in the nature thereof, and any and all advances, renewals, substitutions, extensions or modifications of any of the foregoing (collectively, a "Mortgage") which may now or hereafter affect Landlord's fee interest in and/or leasehold title to the Land or Building. Tenant shall within ten (10) days of Landlord's written request execute, acknowledge and deliver to Landlord, Landlord's designee, and/or Mortgagee, the following: (i) such certificate or certificates that may be requested by Landlord or such Mortgagee to evidence the subordination of this Lease to such Mortgage; (ii) such certificate or certificates that may be requested by Landlord or such Mortgagee to make this Lease superior to the lien of any such Mortgage; and (iii) such attornment agreements as may be reasonably requested by successors to Landlord hereunder. If a Mortgagee shall hereafter succeed to the rights of Landlord under this Lease, whether through possession or foreclosure action or delivery of a new lease, Tenant shall, at the request of such Mortgagee, attorn to and recognize such successor as Tenant's "Landlord" under this Lease and shall promptly execute and deliver any instrument that may be necessary to evidence such attornment. Tenant agrees that in the event of a sale of the Land or Building by foreclosure or deed in lieu thereof, the purchaser shall be responsible for refunding Tenant's Deposit only to the extent that such purchaser actually receives the Deposit in good funds or by credit to the purchase price.

29. ESTOPPEL CERTIFICATES.

Landlord and Tenant hereby agree that at any time and from time to time during the Term of this Lease, upon not less than ten (10) days' prior written notice from the other party, each party shall execute and deliver to such other party a statement in writing certifying the following: that this Lease is unmodified and in full force and effect, or, if modified, stating the nature of such modification; the date through which the Rent is paid; and acknowledging that there are not, to its knowledge, any uncured defaults on the part of the other party, or specifying the nature of such defaults, if claimed, or any events which, with the giving of notice or the passage of time, or both, would constitute defaults. If either party fails to execute such a statement, then after five (5) days' written notice and opportunity to cure have been given by the other party and expired, each party hereby names, appoints and constitutes the other party as its true and lawful attorney in fact, to execute such a statement on its behalf. Such statements may be conclusively relied upon by any prospective purchaser of the Land or Building, any holder or prospective holder of any Mortgage, or by any permitted subtenant or assignee of Tenant.

30. MODIFICATION OF LEASE.

If in connection with construction or permanent financing, or refinancing of the cost of the Land, Project or Building, a banking or insurance company, or other recognized lender, shall request reasonable modifications to this Lease as a condition to such financing, Tenant will not unreasonably withhold, delay or defer its consent thereto, provided that such modifications do not increase the obligations of Tenant hereunder, or materially adversely affect the leasehold interest of Tenant. Tenant hereby irrevocably appoints Landlord, its successors and assigns, as the attorney-in-fact of Tenant to consent to, execute, seal and deliver such modifications on behalf of Tenant, should Tenant refuse and fail to do so within fifteen (15) days after Landlord shall give written notice to Tenant requesting the execution, sealing and delivery of such instrument. In addition, Landlord shall have the right, exercisable by written notice to Tenant given at any time prior to the date the Premises are substantially completed, to cancel this Lease if the Tenant fails or refuses to approve in writing any such modification within fifteen (15) days after Landlord's request therefor. If such right to cancel is exercised, neither party shall have any further obligations or liabilities hereunder, except that Landlord shall repay to Tenant any Deposit made by Tenant.

31. REAL ESTATE BROKERS.

Tenant and Landlord represent and warrant to each other that no real estate broker, agent, commissioned salesperson, or other person has represented the warranting party in the negotiations for and procurement of this Lease and of the Premises, other than Landlord's leasing agent for the Project, and that no commissions, fees or compensation of any kind are due and payable in connection herewith to any real estate broker, agent, commissioned salesperson or other person (including all persons or firms excluded above from the foregoing warranty) unless and only as may be provided in a separate written commission agreement signed simultaneously with or before this Lease by the party against whom the commission or compensation is charged. Each party agrees to indemnify and hold the other harmless from and against any claim for any such commissions, fees, or other form of compensation by any such third party claiming through the indemnifying party, including, without limitation, any and all claims, causes of action, damages, costs and expenses (including attorneys' fees), associated therewith.

32. TRANSFER OF TENANT.

If the square feet in the Premises are 1,000 square feet or less, Landlord hereby reserves the right, at its sole option and upon giving at least sixty (60) days' written notice in advance to Tenant, to transfer and remove Tenant from the Premises from time to time to any other available space in the Building of substantially equal area and equivalent rental. Landlord hereby agrees to bear the reasonable expense of such transfer and removal, as well as the reasonable expense of any renovations or alterations which are necessary to make the new space conform substantially in layout and appointment with the Premises. After each such transfer, the new premises shall become the Premises for all purposes under this Lease.

33. MISCELLANEOUS.

A. Severability and Interpretation.

If any clause or provision of this Lease shall be deemed illegal, invalid, or unenforceable under present or future laws effective during the Term of this Lease, then and in that event, the parties agree that the remainder of this Lease shall not be affected by such illegality, invalidity or unenforceability, and the remainder of this Lease shall remain in full force and effect. Should any of the provisions of this Lease require judicial interpretation, it is agreed that the court interpreting or construing the same shall not apply a presumption that the terms of any such provision shall be more strictly construed against one party by reason of the rule of construction that a document is to be construed most strictly against the party who itself or through its agent prepared the same, it being agreed that the agents of all parties have participated in the negotiation and preparation of this Lease.

B. Waiver of Jury Trial.

In any action or proceeding brought by either party to declare or enforce the rights of the parties under this Lease, each party hereby waives its right to a trial by jury in such action.

C. Captions.

The headings or titles to the paragraphs and subparagraphs of this Lease are not part of the Lease, but are inserted for convenience only and shall have no effect upon the construction or interpretation of any part of this Lease.

D. Successors and Assigns.

"Landlord," as used herein, shall include Landlord, its heirs, successors, legal representatives and assigns. "Tenant," as used herein, shall include Tenant, its heirs, successors, legal representatives, subtenants and assigns. The provisions of this Lease shall be binding upon and shall inure to the benefit of the parties hereto, and their respective heirs, executors, administrators, legal representatives, successors and assigns. The terms "Landlord" and "Tenant" shall include the male and female, singular and plural, corporation, partnership or individual, as the same may be applicable.

E. Guaranty. N/A

F. Governing Law.

The laws of the State of Tennessee shall govern the execution, interpretation, validity, performance and enforcement of this Lease. The parties agree that performance of their respective obligations will occur in the county within the State of Tennessee where the Premises are located; both parties waive personal jurisdiction and submit themselves to the jurisdiction and venue of the superior and state courts of such county.

G. Governmental Regulations.

Tenant waives the benefits of all existing and future rent control legislation and statutes and similar governmental rules and regulations, whether in time of war or not, to the full extent permitted by law.

H. Time of Essence.

Time is of the essence of this Lease; provided however, that the failure of Landlord to provide Tenant with notice regarding reimbursements for Operating Expenses, or any other charges or additional Rent provided for hereunder, within the time periods prescribed in this Lease shall not relieve Tenant of its obligation to make such payments or reimbursements.

I. Multiple Counterparts.

This Lease may be executed in multiple counterparts, each of which shall be deemed to be an original for all purposes.

J. Public Records.

Neither party shall record this Lease, or a short form memorandum of this Lease, without the prior written consent of the other party.

K. Multiple Tenants.

If more than one individual or entity comprises and constitutes Tenant or Guarantor, then all individuals and entities comprising Tenant or Guarantor are and shall each be jointly and severally liable for the due and proper performance of Tenant's or Guarantor's duties and obligations arising under or in connection with this Lease and/or the Guaranty. Each party executing this Lease and/or the Guaranty on behalf of Tenant and/or Guarantor, as applicable, represents to Landlord that he or she has the authority to do so in the capacity indicated, and to thereby bind Tenant and/or Guarantor, as applicable.

L. Force Majeure.

Both parties shall be excused for the period of any delay and shall not be deemed in default with respect to the performance of any of the non-monetary terms, covenants, and conditions of this Lease when prevented from so doing by a cause or causes entirely beyond their reasonable control, which shall include war, all labor disputes, governmental regulations or controls, fire or other casualty, inability to obtain any material or services, and acts of God.

M. Special Stipulations.

The terms of any Special Stipulations attached to this Lease are incorporated herein by this reference. To the extent of any conflict between the terms of this Lease and the Special Stipulations, the Special Stipulations shall control.

N. Rules and Regulations.

Tenant covenants and agrees to observe faithfully and strictly comply with the rules and regulations contained in Exhibit "C" (the "Rules and Regulations"), including the Moving Policy set forth in Exhibit "D" and such modifications thereto and/or additional rules and regulations as Landlord may from time to time reasonably adopt for the safety, care and cleanliness of the Project or the preservation of good order therein. Landlord shall not be liable to Tenant for any violation of the Rules and Regulations, or for the breach of any covenants or condition in any lease by any other tenant at the Project, or by the employees, officers, agents, licensees, invitees, visitors, customers, concessionaires, assignees, subtenants, contractors or subcontractors of any other tenants.

O. Entire Agreement.

This Lease contains the entire agreement between the parties hereto and any representation, warranty or agreement, oral or otherwise, between the parties not embodied herein shall be of no force or effect. No officer, agent or employee of Landlord has or shall have any authority to waive any provision of this Lease unless such waiver is expressly made in writing and signed by an authorized officer of Landlord.

P. Amendment of Lease.

No modification, amendment or alteration of this Lease shall be effective unless in writing and signed by Landlord and Tenant.

Q. Enforceability.

This Lease shall not be enforceable until fully executed by Landlord and Tenant.

34. EXECUTION.

As a material inducement to Landlord to enter into this Lease, Tenant (and, individually each party executing this Lease on behalf of Tenant), intending that Landlord rely on each such representation and warranty, represents and warrants to Landlord that:

A. Tenant and the party executing on behalf of Tenant are fully and properly authorized to execute and enter into this Lease on behalf of Tenant and to deliver same to Landlord;

B. The execution, delivery and full performance of this Lease by Tenant do not and shall not constitute a violation of any contract, agreement, undertaking, judgment, statute, regulation, governmental or court order or other restriction of any kind to which Tenant is a party or by which Tenant is or may be bound;

C. Tenant has executed and entered into this Lease free from fraud, undue influence, duress, coercion or other defenses to the execution of this Lease.

D. This Lease constitutes a valid and binding obligation of Tenant, enforceable against Tenant in accordance with the terms of this Lease.

E. Tenant is duly organized, validly existing and in good standing under the laws of the state of Tenant's organization and has full power and authority to enter into this Lease, to perform Tenant's obligations under this Lease in accordance with the terms hereof, and to transact business in the State of Tennessee.

F. The execution of this Lease by the individual or individuals executing this Lease on behalf of Tenant, and Tenant's performance of its obligations under this Lease, have been duly authorized and approved by all necessary corporate or partnership action, as the case may be, and Tenant's execution, delivery and performances of this Lease are not in conflict with Tenant's bylaws or articles of incorporation (if a corporation), agreement of partnership (if a partnership), and other charters, agreements, rules or regulations governing Tenant's business as any of the foregoing may have been supplemented, modified, amended or altered in any manner.

IN WITNESS WHEREOF, the parties hereto have duly executed this instrument, individually or through their respective authorized officers, agents or attorneys in fact, as the case may be, causing their respective seals to be affixed hereto, all as of the date first set forth above.

LANDLORD:	TENANT:
Hickory Grove Commons	HERITAGE HOSPICE AND PALLIATIVE CA LL
DATE: 4/11/2023	DATE: 4/11/23
By:	By: Savannah Hamilton
Its: Director	Its:

Exhibit "A"

Floor Plan

Suite 303

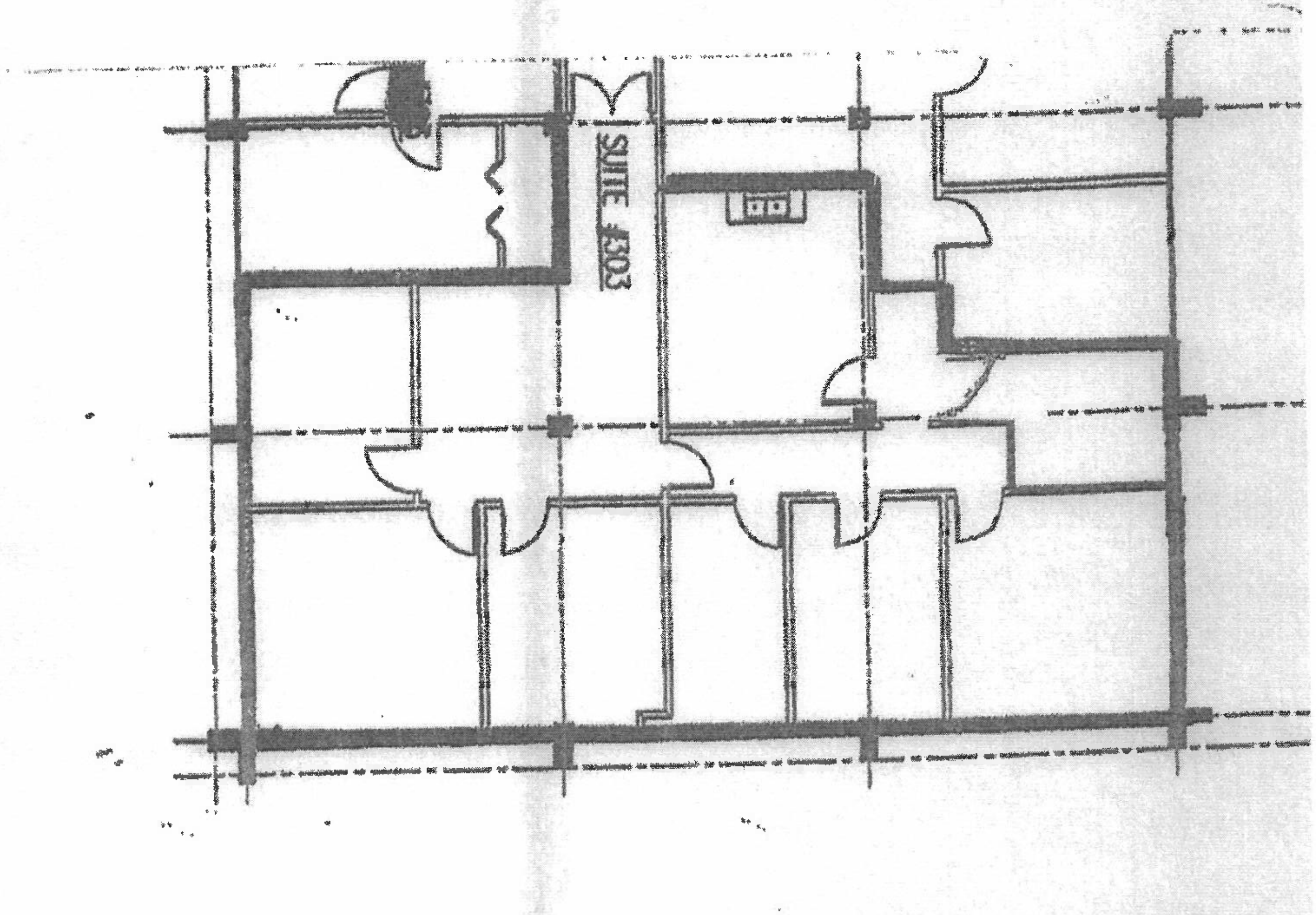


EXHIBIT "B"

Description of Landlord's Work

Landlord shall at his expense do the following:

1. Clean carpets
2. Repair kitchen floor

EXHIBIT "C"

RULES AND REGULATIONS

(1) No sign, picture, advertisement, or notice shall be displayed by Tenant on any part of the Premises or the Building unless the same is first approved by Landlord. Any such sign, picture, advertisement, or notice approved by Landlord shall be painted or installed for Tenant by Landlord at Tenant's expense. No awnings, curtains, blinds, shades, or screens shall be attached to or hung in, or used in connection with any window or door of the Premises without the prior written consent of the Landlord, including approval by the Landlord of the quality, design, color, and manner attached.

(2) Tenant shall not do or permit to be done in or about the Premises or the Building any act which obstructs or interferes with the rights of other tenants of Landlord, or annoy them in any way, including, but not limited to, parking loud or unseemly noises. Tenant shall not use the Premises for manufacturing, storage, or sale of merchandise or property of any kind, sleeping, lodging, or cooking at any time except with Landlord's written permission. Tenant may use for its own employees within its Premises, a conventional coffee-maker and microwave oven but tenant shall be responsible for shutting off such coffee-maker and microwave oven at the close of each business day.

(3) No vending machines of any kind will be installed, permitted or used by Tenant in any part of the Premises without Landlord's written permission. No part of the Building shall be used for gambling, immoral, or unlawful purposes. No intoxicating beverages shall be sold or consumed in the Building without the prior written consent of Landlord. No area outside of the Premises shall be used by Tenant for storage purposes at any time. No bicycles, vehicles, or animals of any kind shall be brought into the Building by Tenant or kept in or about the premises.

(4) The sidewalks, entrances, passages, corridors, halls, elevators, and stairways shall not be obstructed by Tenant or used for any purpose other than those for which same were intended as ingress and egress. No window shall be covered or obstructed by Tenant. Toilets, wash basins, and sinks shall not be used for any purposes other than those for which they were constructed, and no sweeping, rubbish, coffee grounds, or other obstructing substances shall be thrown therein.

(5) No additional lock, latch or bolt of any kind shall be placed upon any door or any changes be made in existing locks or mechanism thereof by Tenant without the consent of Landlord, and such consent of Landlord shall be required by Tenant in writing.

(6) Tenant shall not cause or permit any unusual or objectionable odors to be produced upon or issue from the Premises, and no flammable, combustible or explosive fluid, chemical or substance shall be brought into the Building by Tenant.

(7) Tenant shall be responsible for locking all entrance doors to the Premises upon the conclusion of the business day. Tenant assumes full responsibility for protecting the Premises from theft, robbery and pilferage. Except during Tenant's normal business hours, Tenant shall keep all doors to the Premises locked and other means of entry of the Premises closed and secured. Landlord shall not be responsible for any lost or stolen property, equipment, money or jewelry from the Premises regardless of whether such loss occurs when the Premises are locked or not.

(8) No safes, furniture, boxes, large parcels, or other kind of freight shall be taken to or from Premises by Tenant or allowed in any elevator, hall, or corridor at any time except by permission of, and at all times allowed by, Landlord. The persons employed to move Tenant's articles must be approved by Landlord; provided, however Landlord acknowledges it has approved any nationally recognized fully insured professional mover.

(9) The Building shall be open to Tenant, its employees, and business visitors during such business hours as are deemed standard by Landlord from time to time on all days except Saturday after 12 p.m., Sundays and holidays. At all other times every person, including Tenant, its employees and visitors entering and leaving the Building may be questioned by a watchman as to that person's business therein, and may be required to sign such person's name· on a form provided by Landlord for registering such person.

(10) Tenant shall not employ any person other than Landlord's contractor or employees for the purpose of cleaning and taking care of the Premises.

(11) All decoration of the Premises, including design, color selection, and finish work, which is visible from any corridor, elevator or other such common areas, shall be made only with specific written approval from Landlord, and in the absence of such approval, Landlord may require Tenant to remove undesirable decoration and restore the Premises to its former condition. Landlord shall provide Tenant with a list of approved subcontractors from which Tenant must choose to do finish work; provided, however, if Tenant desires to use a subcontractor not so listed, Tenant will provide Landlord with references and other supporting documentation for such subcontractor reasonably satisfactory to Landlord and Landlord's approval thereof shall not be unreasonably withheld, conditioned or delayed.

(12) Tenant shall make sure that all Premises doors that open into common areas are kept closed except when being used for ingress and egress.

(13) Landlord shall have the right to prohibit any advertising by any tenant which, in Landlord's opinion, tends to impair the reputation of the Building or its desirability for offices, and upon written notice form Landlord, Tenant shall refrain from or discontinue such advertising.

(14) Tenant shall not overload any floor and shall not install any heavy objects, large business machines, large files or other equipment without having receiving Landlord's prior written consent as to size, maximum weight, routing and location thereof.

(15) No tenant shall mark, paint, drill into, or in any way deface any part of the Premises or the Building. No boring, cutting or stringing of wires shall be permitted, except with the prior written consent of Landlord, and as the Landlord may direct.

(16) Canvassing, soliciting, and peddling in the Building are prohibited and each tenant shall cooperate to prevent the same.

(17) The Common Areas and individual premises at One and Two Northgate Park are Non-Smoking. Common Areas include all hallways, stairwells, restrooms, lobbies, elevators, elevator lobbies and any public areas. Also included is the exterior of entrance and exit doors within a 50 foot radius.

(18) This edition of Rules and Regulations shall be effective immediately and from time to time may be supplemented and amended by Landlord, Landlord shall not be responsible to Tenant for the non-observance, or violation, of any of these Rules and Regulations by other tenants of the Building.

EXHIBIT "D"

MOVING POLICY

Each moving company transporting supplies, furniture and/or equipment through the Premises are to contact the Property Manager at lease twenty-four (24) hours before the move takes place.

1. The route to be followed in the Building during the move must be approved by the Landlord. The moving company must provide and install adequate protective coverings on all vulnerable corners, walls, door facings, elevator cabs and other areas along route to be followed during the move. These areas will be inspected for damage after the move.

2. Clean masonite sections must be used as runners on all finished floor areas where heavy furniture or equipment is being moved with wheel or skid-type dollies. The masonite must be at least one-fourth inch thick. All sections of masonite should be taped to prevent sliding.

3. Do not stick duct tape onto the floors, walls, door jambs, or doors.

4. All vendor and moving company boxes and cartons are to be removed from the Premises and the Building by the vendor or moving company. They are not to be disposed of in the Building's dumpster.

5. It is the Tenant's responsibility to notify Landlord of items to be moved which are unusually large or heavy (in excess of 3,500 pounds) or which may require review by Landlord. Dimensions and weight may prohibit safe transport and placement within acceptable structural guidelines. Any large items that cannot be placed in the elevator will require special hoisting arrangements which will be made through the Landlord. Tenants moving company should include the bid price to the Tenant any additional charges required for extra service which may need to be provided by the moving company to hoist large items.

6. Access control personnel will be notified as to the move-in-schedule and will monitor the progress of the move. Any changes in the move-in schedule must be reported to the Landlord or Landlord's representative immediately. An emergency phone number will be required by the access control personnel for the moving company's supervisor and for the Tenants representative responsible for coordinating the move.

7. When ordering equipment, furniture, supplies, etc. at any time before or after your move, please specify Inside Delivery to your suite, because Landlord is not responsible for deliveries from the loading dock or Building common areas to your suite.

8. All move-in times are to be arranged prior to move in with a representative of the Landlord.

Warranty Deed Evidencing Landlord Ownership

Name and Address of New Owner:
Hickory Grove Community, LLC
5911 Ringgold Road
Chattanooga, TN 37412

Send Tax Bills To:
Hickory Grove Community, LLC
5911 Ringgold Road
Chattanooga, TN 37412

This Instrument Prepared By:
Debbie Hayworth-Underwood
CHOICE TITLE COMPANY, Inc.
Mail 7703 Nashville Street
Ringgold, GA 30736

Map & Parcel No: 110H-E-004.03

Book/Page: **GI 11445 / 834**
Instrument 2018090500238
4 Page WARRANTY DEED Value of $2,460,000.00
Recorded by KDS on 9/5/2018 at 2:54 PM

DEED RECORDING FEE	20.00
DATA PROCESSING FEE	2.00
CONVEYANCE TAX	9,102.00
PROBATE FEE	1.00
TOTAL FEES	$9,125.00

State of Tennessee Hamilton County Register of Deeds MARC GRAVITT

WARRANTY DEED

~~15~~

OKS - 1879, 1845, 1897, 1901

FOR AND IN CONSIDERATION of the sum of Ten Dollars ($10.00) cash in hand paid, and other good and valuable consideration, the receipt and legal sufficiency of which are hereby irrevocably acknowledged, **Northgate Park Properties, LLC, a Tennessee Limited Liability Company**, "the Grantor," has this day bargained and sold and by these presents does hereby sell, give, transfer and convey unto **Hickory Grove Community, LLC, a Georgia Limited Liability Company**, "the Grantee," the following described real estate in Hamilton County, Tennessee:

> All that tract or parcel of land lying and being in the First Civil District of Hamilton County, Tennessee and being more particularly described as follows: TO FIND THE POINT OF BEGINNING commence at the southwestern or westernmost corner of the L. B. Austin, Jr., property, said corner being located in the southeastern line of Hixson Pike; thence southwestwardly along the southeastern line of Hixson Pike, as it curves to the left on a radius of 1,394.39 feet, a distance of 84.23 feet TO THE POINT OF BEGINNING; thence south 65 degrees 38 minutes 00 seconds east a distance of 346.03 feet to a point; thence south 24 degrees 22 minutes 00 seconds west a distance of 259 feet to a point; thence north 65 degrees 38 minutes 00 seconds west a distance of 419.91 feet to a point in the southeast line of Hixson Pike; thence north 36 degrees 22 minutes 00 seconds east with and along the southeast line of Hixson Pike a distance of 42.83 feet to a point; thence northwardly with and along the southeast line of Hixson Pike as it curves to the right on a radius of 1,394.39 feet, an arc distance of 226.62 feet to the point of beginning.
>
> TOGETHER WITH a Perpetual Easement, 30 feet in width, south of and contiguous to the southern line of the herein described property for the purpose of ingress and egress.
>
> TOGETHER WITH a Permanent Easement 30 feet in width south of and contiguous to the southern line of the herewith described property and extending westwardly from the western line of the herein described property to the eastern line of Hixson Pike for the purposes of ingress, egress and the installation and maintenance of utilities.
>
> SUBJECT TO AND TOGETHER WITH a Joint Access Easement as setout in Plat Book 35, page 365 in the Register's Office of Hamilton County, Tennessee.
>
> Property known as: 2120 Northgate Park Lane, Chattanooga, TN 37415
> Map Parcel: 110H-E-004.03
>
> For prior title see Warranty Deed from Opyt, LLC to Northgate Park Properties, LLC dated July 29, 2016 and recorded on July 29, 2016 in Book 10811, page 17 in the Register's Office of Hamilton County, Tennessee.

THIS CONVEYANCE IS MADE SUBJECT TO THE FOLLOWING:

Any governmental zoning and subdivision ordinances or regulations in effect thereon.

All applicable conditions, restrictions, reservations, easements, etc. as shown on recorded plat.

All matters as shown or stipulated on recorded plat.

The accuracy of the Index Book of the said Register's Office; and any other matters which an accurate survey of the Property might disclose.

Subject to South Central Bell Telephone Communication Easement as setout in Book 2208, page 642 in the Register's Office of Hamilton County, Tennessee.

Subject to an Easement to Electric Power Board as setout in Book 2661, page 723 in the Register's Office of Hamilton County, Tennessee.

Subject to an Easement Agreement as setout in Book 2142, page 7 and Book 2340, page 595 in the Register's Office of Hamilton County, Tennessee.

Subject to a 16 foot Easement to Electric Power Board as setout in Plat Book 35, page 265 in the Register's Office of Hamilton County, Tennessee.

Subject to a 20 foot Easement to Electric Power Board as setout in Book 1977, page 900 and Plat Book 35, page 365 in the Register's Office of Hamilton County, Tennessee.

Subject to a Private Sanitary Sewer Easement as setout in Plat Book 35, page 365 in the Register's Office of Hamilton County, Tennessee.

Subject to Permanent Drive and Access Easements are to be Privately Maintained as noted in Plat book 35, page 365 in the Register's Office of Hamilton County, Tennessee.

Subject to Agreement as setout in Book 2108, page 34 and as Amended in Book 3128, page 205 in the Register's Office of Hamilton County, Tennessee.

Subject to Terms and Provisions of Agreement as setout in Book 1936, page 563 and as Amended in Book 1974, page 85, Book 2074, page 755 and Book 2181, page 105 in the Register's Office of Hamilton County, Tennessee.

Subject to Assignment and Assumption of Operating Agreement as setout in Book 3744, page 713, Book 5472, page 978, Book 5513, page 918 and Book 9490, page 347 in the Register's Office of Hamilton County, Tennessee.

Subject to Easement as setout in Book 1945, page 380 in the Register's Office of Hamilton County, Tennessee.

Subject to Easement Agreement as setout in Book 2326, page 471 in the Register's Office of Hamilton County, Tennessee.

Subject to Declaration of Easements as setout in Book 2802, page 366 in the Register's Office of Hamilton County, Tennessee.

Subject to Water Line Easement as setout in Book 2954, page 513 in the Register's Office of Hamilton County, Tennessee.

Subject to all matters as shown or specified in Plat Book 35, page 365 in the Register's Office of Hamilton County, Tennessee.

Subject to memorandum of Lease as setout in Book 2062, page 795 and as Amended in Book 2340, page 600 in the Register's Office of Hamilton County, Tennessee.

Subject to Tenants in possession.

Subject to Rights or Claims of Parties in Possession under oral or written, but unrecorded, Lease or Rental Agreements which affect the herein described property.

Any governmental zoning and subdivision ordinances or regulations in effect thereon.

All applicable conditions, restrictions, reservations, easements, etc. as shown on recorded plat.

The accuracy of the Index Book of the said Register's Office; and any other matters which an accurate survey of the Property might disclose.

TOGETHER WITH any and all the rights, privileges, easements, improvements and appurtenances to the same belonging.

TO HAVE AND TO HOLD said real estate unto the Grantee, and the Grantee's successors, heirs and assigns, forever in fee simple.

Grantor covenants that it is lawfully seized and possessed of said real estate, has good right and lawful authority to convey the same, that the title thereto is clear, free and unencumbered (except as hereinbefore specifically set out), and will forever warrant and defend said title against any and all lawful claims of all persons.

IN WITNESS WHEREOF, Grantor has caused this Warranty Deed to be executed on the 28th day of August, 2018.

Northgate Park Properties, LLC, a Tennessee
Limited Liability Company

By:
Raymond T. McDowell, Member

By:
Forrest W. McNair, Member

By:
Susan Melissa McNair

STATE OF GEORGIA)
)
COUNTY OF CATOOSA)

Before me, a Notary Public of the State and County aforesaid, personally appeared Raymond T. McDowell, Member, Forrest W. McNair and Susan Melissa McNair, Members with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged themselves to be the MEMBERS of Northgate Park Properties, LLC, the within named bargainor, a Limited Liability Company, and that they as such officer, executed the foregoing instrument for the purpose therein contained, by personally signing the name of the Limited Liability Company by themselves as such MEMBERS .

WITNESS my hand and official seal this 28th day of August, 2018.

Notary Public
My commission expires: My Commission Expires: October 5, 2019

SAMUEL GOWIN

AFFIDAVIT OF VALUE

STATE OF GEORGIA)
)
COUNTY OF CATOOSA)

The undersigned hereby offers this instrument for recording within the meaning of the statutes of the State of Tennessee under Tenn. Code Ann. Section 67-4-409, and hereby swears and affirms that the actual consideration for this transfer or value of the property transferred, whichever is greater, is $2,460,000.00, which amount is equal to or greater than the amount which the property transferred would command at a fair and voluntary sale.

(Affiant) Joseph W. William

Sworn to and subscribed before me this
28th day of August, 2018.

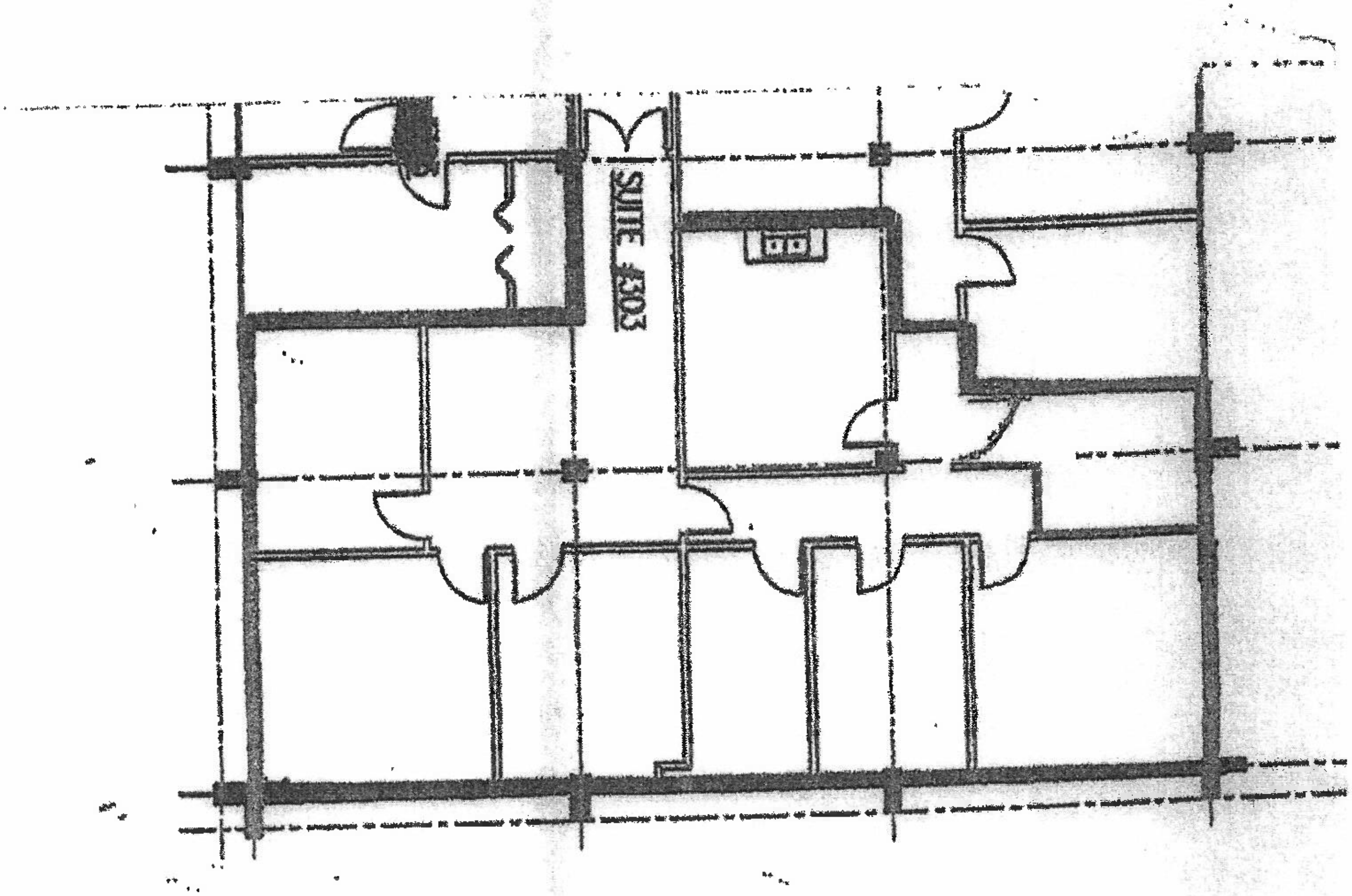
Notary Public
My commission expires: My Commission Expires: October 5, 2019
File No. 7575-18-TN

SAMUEL GOWIN
NOTARY PUBLIC
WHITFIELD COUNTY, GEORGIA

Exhibit "A"

Floor Plan

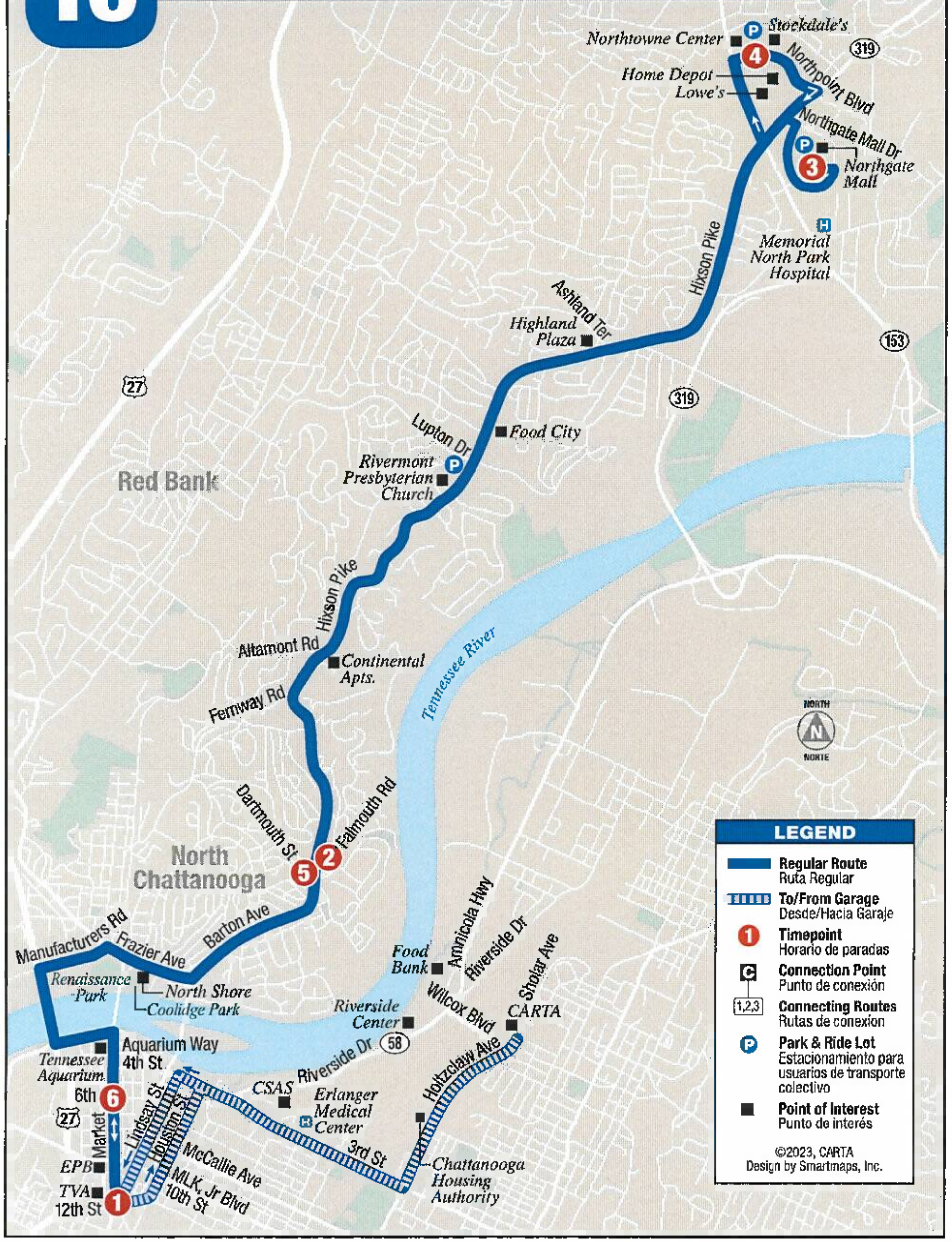
Suite 303



ATTACHMENT 11A

Public Transportation Routes

16 Northgate • Monday–Sunday / Lunes–Domingo



Route 16 Northgate

HOLIDAY SERVICE: Route not in service on New Year's Day, Easter, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. On Martin Luther King, Jr. Day and Memorial Day, buses run on a Saturday schedule. / HORARIO EN DÍAS FESTIVOS: No hay ruta el día de Año Nuevo, Pascua, día de Independencia, día del Trabajo, día de Acción de Gracias y Navidad. El día de Dr. Martin Luther King, Jr. y en el día de Homenaje a los Caídos (Memorial Day) los buses viajan de acuerdo con el horario del sábado.

MONDAY–FRIDAY / LUNES–VIERNES • 5:45 AM – 10:40 PM

	Outbound from Downtown / Saliendo del Centro					Inbound to Downtown / De ida hacia el Centro				
	Bus comes from / Bus viene de	1 12th & Market	2 Falmouth & Hixson Pike	3 Northgate Mall		3 Northgate Mall	4 Hwy. 153 & Northpoint Blvd. (Home Depot)	5 Dartmouth & Hixson Pike	6 6th & Market	Bus goes to / Bus va hacia
AM	G-5:45	6:00	6:15	6:30	AM	6:30	6:35	6:50	7:05	9
	G-6:15	6:30	6:45	7:00		7:00	7:05	7:20	7:35	9
	9	7:05	7:20	7:35		7:35	7:40	7:55	8:10	9
	9	7:35	7:50	8:05		8:05	8:10	8:25	8:40	9
	9	8:10	8:25	8:40		8:40	8:45	9:00	9:15	9
	G-8:30	8:45	9:00	9:15		9:15	9:20	9:35	9:50	9
	G-9:05	9:20	9:35	9:50		9:50	9:55	10:10	10:25	9
	9	9:55	10:10	10:25		10:25	10:30	10:45	11:00	G-11:20
	9	10:30	10:45	11:00		11:00	11:05	11:20	11:35	9
	G-10:50	11:05	11:20	11:35		11:35	11:40	11:55	12:10	9
PM	9	11:40	11:55	12:10	PM	12:10	12:15	12:30	12:45	9
	9	12:15	12:30	12:45		12:45	12:50	1:05	1:20	9
	9	12:50	1:05	1:20		1:20	1:25	1:40	1:55	G-2:15
	9	1:25	1:40	1:55		1:55	2:00	2:15	2:30	G-2:50
	G-1:45	2:00	2:15	2:30		2:30	2:35	2:50	3:10	9
	G-2:20	2:35	2:50	3:05		3:05	3:10	3:25	3:40	G-4:00
	9	3:10	3:25	3:40		3:40	3:45	4:00	4:15	9
	9	3:45	4:00	4:15		4:15	4:20	4:35	4:50	9
	9	4:25	4:40	4:55		4:55	5:00	5:15	5:30	9
	9	4:55	5:10	5:25		5:25	5:30	5:45	6:00	9
	9	5:30	5:45	6:00		6:00	6:05	6:20	*6:30	9
	9	6:00	6:15	6:30		6:30	6:35	6:50	7:05	G-7:25
	9	*6:30	6:45	7:00		7:00	7:05	7:20	*7:30	9
	9	*7:30	7:45	8:00		8:00	8:05	8:20	*8:30	9
	9	*8:30	8:45	9:00		9:00	9:05	9:20	*9:30	9
	9	*9:30	9:45	10:00		10:00	10:05	10:20	10:30	G-10:40

G- Indicates when the bus leaves or arrives at the CARTA Garage. See To/From Garage routing on map. / Indica cuándo el bus sale o llega al garaje de CARTA. Ver en el mapa la ruta de servicio Desde/Hacia Garaje.

* Indicates trips where buses line up on Market Street for ease in transferring to other routes. / Indica viajes donde los buses forman una línea en Market Street para facilitar el trasbordo hacia otras rutas.

Schedules continued next page / Los horarios siguen en la próxima página →

Route 16 Northgate

Please see map on page 62
Favor ver el mapa en la página 62

Continued from previous page / *Continuación de la página anterior*

SATURDAY / SÁBADO • 6:40 AM – 10:40 PM

	Outbound from Downtown / Saliendo del Centro				Inbound to Downtown / De ida hacia el Centro				
	Bus comes from / Bus viene de	① 12th & Market	② Falmouth & Hixson Pike	③ Northgate Mall	③ Northgate Mall	④ Hwy. 153 & Northpoint Blvd. (Home Depot)	⑤ Dartmouth & Hixson Pike	⑥ 6th & Market	Bus goes to / Bus va hacia
AM	G-6:40	6:55	7:10	7:25	7:25	7:35	7:45	8:00	9
AM	9	7:40	7:55	8:10	8:10	8:15	8:25	8:40	9
AM	9	8:15	8:30	8:45	8:45	8:50	9:00	9:15	G-9:35
AM	9	9:00	9:15	9:30	9:30	9:40	9:50	10:05	9
AM	9	9:40	9:55	10:10	10:10	10:20	10:30	10:45	9
AM	9	10:20	10:35	10:50	10:50	11:00	11:10	11:25	9
AM	9	11:05	11:20	11:40	11:40	11:45	11:55	12:15	9
AM / PM	G-11:30	11:45	12:00	12:20	12:20	12:25	12:35	12:55	9
PM	9	12:25	12:40	1:00	1:00	1:05	1:15	1:35	9
PM	9	1:15	1:30	1:50	1:50	1:55	2:05	2:25	G-2:45
PM	9	1:55	2:10	2:30	2:30	2:35	2:50	3:10	16
PM	9	2:35	2:50	3:10	3:10	3:15	3:25	3:45	G-4:05
PM	9	3:00	3:15	3:35	3:35	3:40	3:50	4:10	9
PM	9	3:25	3:40	4:05	4:05	4:10	4:20	4:40	9
PM	9	4:10	4:25	4:45	4:45	4:55	5:05	5:20	9
PM	9	4:40	4:55	5:15	5:15	5:20	5:35	5:50	16
PM	9	5:10	5:25	5:45	5:45	5:50	6:05	6:20	9
PM	9	5:40	5:55	6:15	6:15	6:20	6:30	6:45	G-7:05
PM	16	6:00	6:15	6:30	6:30	6:35	6:45	7:00	9
PM	9	*6:30	6:45	7:00	7:00	7:05	7:15	*7:30	4
PM	9	*7:30	7:45	8:00	8:00	8:05	8:15	*8:30	9
PM	9	*8:30	8:45	9:00	9:00	9:05	9:15	*9:30	9
PM	9	*9:30	9:45	10:00	10:00	10:05	10:15	10:25	G-10:40

G- Indicates when the bus leaves or arrives at the CARTA Garage. See To/From Garage routing on map. /
Indica cuándo el bus sale o llega al garaje de CARTA. Ver en el mapa la ruta de servicio Desde/Hacia Garaje.

* Indicates trips where buses line up on Market Street for ease in transferring to other routes. /
Indica viajes donde los buses forman una línea en Market Street para facilitar el trasbordo hacia otras rutas.

Schedules continued next page / *Los horarios siguen en la próxima página* →

Route 16 Northgate

Please see map on page 62
Favor ver el mapa en la página 62

Continued from previous page / *Continuación de la página anterior*

SUNDAY / DOMINGO • 8:45 AM – 8:00 PM

	Outbound from Downtown / Saliendo del Centro				Inbound to Downtown / De ida hacia el Centro				
	Bus comes from / Bus viene de	① 12th & Market	② Falmouth & Hixson Pike	③ Northgate Mall	③ Northgate Mall	④ Hwy. 153 & Northpoint Blvd. (Home Depot)	⑤ Dartmouth & Hixson Pike	⑥ 6th & Market	Bus goes to / Bus va hacia
AM	G-8:45	*9:00	9:15	9:35	9:35	9:40	9:55	*10:10	9
AM	9	*10:10	10:25	10:45	10:45	10:50	11:05	*11:20	9
AM	9	*11:20	11:35	11:55	11:55	12:00	12:15	*12:30	9
PM	G-12:09	*12:30	12:45	1:05	1:05	1:10	1:25	*1:40	9
PM	9	*1:40	1:55	2:15	2:15	2:20	2:35	*2:50	9
PM	9	*2:50	3:05	3:25	3:25	3:30	3:45	*4:00	9
PM	G-3:55	4:10	4:25	4:45	4:45	4:50	5:05	*5:20	9
PM	9	*5:20	5:35	5:55	5:55	6:00	6:15	*6:30	9
PM	9	*6:30	6:45	7:05	7:05	7:10	7:25	7:40	G-8:00

G- Indicates when the bus leaves or arrives at the CARTA Garage. See To/From Garage routing on map. /
Indica cuándo el bus sale o llega al garaje de CARTA. Ver en el mapa la ruta de servicio Desde/Hacia Garaje.

* Indicates trips where buses line up on Market Street for ease in transferring to other routes. /
Indica viajes donde los buses forman una línea en Market Street para facilitar el trasbordo hacia otras rutas.

ATTACHMENT 1N-2

Letters of Support

erlanger
Health System

ANGEL MOORE, ESQ.
CHIEF EXECUTIVE OFFICER
ERLANGER HEALTH CENTERS

1200 Dodson Avenue
Chattanooga, TN 37406
www.erlanger.org

(423) 778-2805
Fax: (423) 778-2868
e-mail: Angel.Moore@erlanger.org

May 2, 2023

Mr. Logan Grant
Health Facilities Commission
500 Deaderick Street
Nashville, TN

RE: Hospice CON Application for Heritage Hospice and Palliative Care

Dear Mr. Grant:

I am pleased to provide my support for Heritage Hospice to establish a new hospice in southeast Tennessee. I currently serve as the Chief Executive Officer for the Erlanger Community Health Centers (ECHC) and Vice President of Population Health for Erlanger Health System. I lead and oversee operations for a comprehensive, integrated community centered safety net program that delivers primary care to patients regardless of their ability to pay. Some of our services include Adult Primary Care, Pediatrics, Obstetrics and Gynecology, Mental & Behavioral Health, Laboratory, Radiology, Pharmacy and Dental Services. Coupled with the integrated primary care services, I manage a host of supportive enabling services to include chronic disease management and services to eliminate social determinates of health barriers. Many of our patients have chronic life-limiting diseases. With our mission to serve the medically indigent, and other underserved persons, over 51% of healthcare services we provide are rendered to African Americans and other racial/ethnic minorities.

As a community safety net leader am involved first-hand in our delivery of healthcare and witness firsthand that many of our patients require education of various aspects of the healthcare system, continuum of healthcare services, and services which are funded through Medicaid and Medicare. We do our best to direct our patients to seek and receive quality healthcare in all phases of their life. Notwithstanding our efforts, we regularly observe that our patients go without end of life home hospice care due to lack of knowledge, resources or understanding. The existing end of life programs in our market have very low numbers for this population of which the goal is to dispel with the disparities in access to such care by minorities.

Our safety net would value a new hospice provider that has a commitment and mission to raise hospice awareness and enrollment for this population throughout our service areas. Having engaged with Heritage Hospice, we believe Heritage Hospice will be that provider. I will work with Heritage to educate, counsel and ultimately enhance hospice utilization amongst this minority population in southeast Tennessee, including our patients.

The disparity of hospice utilization is significant and can only be addressed through CON approval of Heritage Hospice. Please approve Heritage Hospice to provide hospice services in southeast Tennessee so that we may work together to enhance end of life care thereby improving quality for the minorities in our service area. Thank you in advance for your consideration and approval.

Sincerely,

Angel Moore, Esq.
Community-Indigent Advocate
Chief Executive Office
Erlanger Community Health Centers

Greg Funderburg
Director of Marketing
and Development

401 E. M.L. King Blvd.
Suite 301
Chattanooga, TN 37403

P (423) 756-1762 ext.13
F (423) 756-7255

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www.ulchatt.net

Urban League of
Greater Chattanooga, Inc.

Empowering Communities.
Changing Lives.

March 28, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
500 Deaderick Street
Nashville, TN

Dear Mr. Grant:

My name is Greg Funderburg. I am the marketing director with the Urban League of Greater Chattanooga and former weekday morning/noon news anchor at WTVC News Channel 9 in Chattanooga Tennessee. I am a member of the National Association of Black Journalists and Kappa Alpha Psi Fraternity, Inc. Aside from my civic work, I enjoy speaking to youth about the importance of education, hard work, determination and dedication. I make it my number one priority to give back to my local community.

I have had the opportunity to meet with Tywanna Hamilton of Heritage Hospice. In my short time of meeting with her, I know my community, as a whole would benefit from having a hospice that's focused on educating the community about hospice to bridge the gap for our minority population in accessing the much needed end-of-life care through hospice.

Allowing Heritage Hospice to establish a hospice in our community which will educate the African American population on these programs, enhance access and provide meaningful end of life care is important to us collectively.

Please approve Heritage Hospice's Certificate of Need Application to establish a hospice program in our region. Heritage Hospice will quickly assimilate into our community and provide access to a much-needed service.

Thank you,

Greg Funderburg

The Stewart Foundation
"REACHING THE WORLD TODAY,
FOR TOMMOROW'S FUTURE"
☎ (423) 320-1536
@ GAVINSTEWART@GMAIL.COM
3335 RINGGOLD ROAD
SUITE 203, CHATTANOOGA, TN 37412

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
500 Deaderick Street
Nashville, TN

Dear Mr. Grant:

My name is Gavin Lynn Steward. I am the CEO / Director of Nivag Ministries International and outreach board member of Pneuma Christian Center. I am a community advocate at large traveling and teaching the word of God locally and internationally. I have a passion for outreach and believe in giving back to those in need. My history of outreach reaches more than locally in Tennessee. I am known for my Credit Knowledge Classes where I teach finance through biblical principles.

I am a fierce advocate to the elderly, so when I was approached by Heritage Hospice and learned of their efforts my ears opened wide. In my meeting with Heritage Hospice leadership, I knew I was hearing many shared passions and that my community would benefit from having a hospice focused on our elderly minority population and educating the community about hospice. The end-of-life care is so important to elderly minority population.

Allowing Heritage Hospice to establish a hospice in our community which will educate the elderly black population on these programs, enhance access and provide meaningful end of life care is important to my community.

Please approve Heritage Hospice's Certificate of Need Application to establish a hospice program in our region. Heritage Hospice will quickly assimilate into our community and provide access to a much-needed service.

Kind Regards,

Gavin Lynn Stewart, MBA, BSBA
CEO / Director, Nivag Ministries International

Smith Bone Consulting Group, LLC

Business and Marketing Strategies For Growth

April 5, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
500 Deaderick Street
Nashville, TN 37243

RE: HERITAGE HOSPICE CERTIFICATE OF NEED APPLICATION

Dear Mr. Grant:

My name is Vickye Bone and for the past four years I was Vice President of Programs & Operations at the Urban League of Greater Chattanooga, with responsibility to manage a program for small business owners who were in start-up or expansion phase. With more than 15 years of experience working with small business entrepreneurs, I now serve as a strategy/marketing consultant. I firmly believe that Heritage Hospice is on the road to great success in Tennessee. They have a service that is greatly needed in the community, and leadership with extensive experience in this sensitive area of healthcare. When reviewing businesses, my first concern is whether leadership has a plan and strategy that will lead them to success. With Heritage Hospice I give a resounding "yes" when responding to this question, as the leadership team has demonstrated an excellent understanding of how their services will fit into the Chattanooga market. They are also prepared to do the "feet on the ground" work necessary to truly engage the community.

Though healthcare has improved significantly for all Americans, one constant is that life expectancy for African Americans lags that of Whites. The African American community has less access to appropriate health care, including preventative care, and that leads to higher incidences of obesity, cancer, and other chronic illnesses that become fatal. People of color often receive a disease diagnosis at late stages with worse outcomes. Therefore, African Americans are not only more susceptible to disease and illness, they are also more likely to die from them.

Johns Hopkins Medicine researchers published a report which indicates that African American patients seek more medically intensive treatment and multiple emergency room visits in the last six months of life, while White patients more often choose hospice services. The researchers found that 34.9% of African Americans who died used hospice services over the study period, compared with 46.2% of Whites. Spiritual beliefs, cultural systems, and mistrust of the medical system help explain Black patients' preferences for life-sustaining treatments.

There is also less engagement in planning end-of-life strategies and thus less use of hospice and palliative care. Inadequate physician communication can also cause patients to misunderstand, and thus fail to utilize, hospice services.

With this information as a backdrop, I had the opportunity to meet with Tywanna Hamilton, President of Heritage Hospice, who has developed an in-home hospice program to meet the end of life care needs for the terminally ill African-American population. Knowing our community, I am able to state first hand that the Chattanooga African-American population is disadvantaged when it comes to accessing hospice services. They aren't aware of its benefits, when to access such a program and may even be skeptical to seek services for their passing. Knowing that a hospice program is covered by Medicare and Medicaid would also be important to our constituents as the benefit not only covers the care but also supplies, pharmacy and other necessities. Heritage Hospice has shared with me their plan to lift up the African-American population in our area by enhancing access to hospice services through education, relationship building and high quality services in the person's home.

I support the Heritage Hospice approach to delivering services. The Tennessee Health Facilities Commission approval of the Heritage Hospice certificate of need application to establish a hospice in southeast Tennessee that addresses the underserved needs of our area's African-American population is critical. Once approved, I firmly believe that the African American community will support Heritage Hospice as a superior provider of hospice and palliative care.

Thank you in advance for your approval of this much needed program in the Chattanooga community.

Warm regards,

Vickye Bone

Vickye Bone

Christopher Prater M.D.
Expect a Miracle when God is Present

105 Lee Parkway Dr., Suite A
Chattanooga, TN, 37421

Phone 423-305-1508
Fax 423-305-1514
Emergencies 423-653-7871

Stick With The Winners
And
Stay Until The Miracle Happens

June 29, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
502 Deaderick Street
Nashville, TN

RE: Heritage Hospice CON Support

Dear Mr. Grant:

My name is Christopher Prater, MD. I am a Board Certified family medicine physician practicing in Chattanooga, Hamilton County. I have a diverse practice base given the diversity of this area.

I had the pleasure of meeting with Tywanna Hamilton, representative of Heritage Hospice, regarding Heritage Hospice's plan to establishing an end-of-life hospice program with a focus on the underserved population. With a near 17 percent black population in Hamilton County, that is admirable. It is my belief Heritage Hospice has the knowledge and ability to increase the awareness and access to hospice care within the minority population.

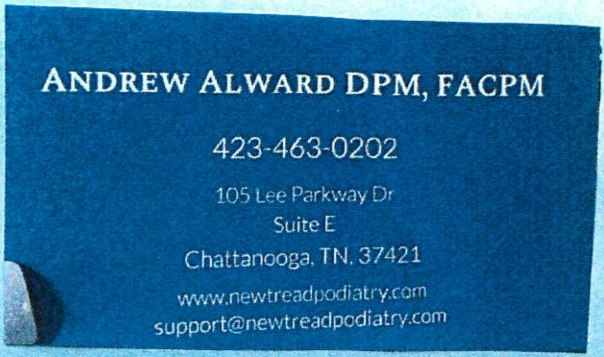
Heritage Hospice has shared with me their plan to lift up the underserved population in our area by enhancing access to hospice services through education, relationship building and high quality services in the person's home. Given their vision, I am in strong support for their Certificate of Need Application Approval to establish an additional hospice program in our community. Once approved, I expect I would refer one to two patients per month to Heritage Hospice.

Please approve the Heritage Hospice CON Application.

Thank you,

Chris Prater, MD

Christopher Prater, MD



ANDREW ALWARD DPM, FACPM

423-463-0202

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Chattanooga, TN, 37421

www.newtreadpodiatry.com
support@newtreadpodiatry.com

June 28, 2023

Logan Grant
Executive Director
Tennessee Health Facilities Commission
502 Deaderick Street
Nashville, TN

RE:
HERITAGE HOSPICE CON APPLICATION
ADDRESSING MINORITY DISPARITIES

Dear Mr. Grant:

My name is Andrew Alward, a physician with NewTread Podiatry in Chattanooga, Hamilton County. I am writing in support of Heritage Hospice's proposal to meet the currently unmet end of life hospice needs of this region's black population.

I have had the opportunity to meet with Tywanna Hamilton of Heritage Hospice. In my short time of meeting with her, I feel confident Heritage Hospice has an appropriate business plan to mitigate the racial disparities in hospice care in our region. Allowing Heritage Hospice to establish a hospice in our community which will educate the black population on these programs, enhance access and provide meaningful end of life care is important to me personally, and to our community.

Given the minority population in our area is underserved, I wholeheartedly support the approval of Heritage Hospice to establish a hospice in this region. We look forward to working with Heritage Hospice upon their licensure.

Please approve Heritage Hospice's CON application so they may address the unmet needs of the terminally ill black patients in this region.

Thank you,

Andrew Alward, DPM, FACPM

June 27, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
502 Deaderick Street
Nashville, TN

RE: Heritage Hospice CON Support

Dear Mr. Grant:

My name is Dr. Anthony G. Avitabile. I am a Board Certified physician and own and operate River City Family Medicine, PLLC located at 6043 Shallowford Rd, Suite 101 in Hamilton County.

In meeting with Heritage Hospice, I was made aware of their plan for establishing an end-of-life hospice program with a focus on the underserved population. It is my belief Heritage Hospice has the knowledge and ability to increase the awareness and access to hospice care within the minority population.

Heritage Hospice has shared with me their plan to lift up the underserved population in our area by enhancing access to hospice services through education, relationship building and high quality services in the person's home.

Understanding their proposed efforts, I am in strong support for their Certificate of Need Application Approval to establish an additional hospice program in our community.

With Heritage Hospice's approval, all in our community will be able to have their end of life needs met by this provider. I look forward to referring to them once established to aid in the education of the minority population.

Sincerely,

Dr. Anthony G. Avitabile, DO, FAAFP
Board Certified

The Waters™
of Sweetwater
A REHABILITATION & SKILLED NURSING CENTER

April 19, 2023

Mr. Logan Grant
Certificate of Need Program
Tennessee Health Facilities Commission
500 Deaderick Street
Nashville, TN

Re: The Waters of Sweetwater Rehab and Nursing Center
Support for Heritage Hospice's CON Application

Dear Mr. Grant:

I am the Operator at The Waters of Sweetwater Rehab and Nursing Center in Monroe County, Tennessee. We are a 90-bed facility located in Sweetwater. We provide an extensive amount of programming for severe chronically ill patients including dialysis, care, ostomy care, chemotherapy, IV therapy, oxygen therapy, tracheostomy care, physical/speech/ occupational therapies and other services for persons with advanced disease stages. We serve Medicare, TennCaare and other payors, including clientele with more limited means, some of whom are minorities.

I understand that Heritage Hospice is submitting a Certificate of Need application to eliminate the racial disparities which are evident in our region with respect to hospice services. I believe Heritage Hospice will add tremendous value to the residents of our service area and should be awarded the CON. The services this company will provide are focused on minorities and not what the local hospice programs provide. And given the unserved need of the black and minority population in our region, it is incumbent on the Health Facilities Commission to authorize Heritage Hospice to provide hospice services in our region.

Heritage Hospice has a culturally competent strategy to address disparities in minority populations, particularly with respect to the Black and Hispanic populations. This strategy will be deployed in our area which will be an invaluable resource where it is proven that both Blacks and Hispanics receive lesser hospice services than the general population. Heritage Hospice, if approved, will augment hospice utilization for these minority groups through education on end-of-life care, comprehensive outreach and specifically tailored programs to enhance minority hospice utilization.

Heritage Hospice will be a great resource for our residents and a wonderful addition to our local healthcare landscape. I hope that in evaluating the need to lift up the black hospice penetration rate in our region, you will agree that Heritage Hospice's CON application should be approved.

Thank you for your consideration.

Sincerely,

Kristie Valentino, BSW, LNHA

978 HIGHWAY 11 SOUTH, SWEETWATER, TN 37874 | T. 423.337-6631

Recuperate. Rejuvenate. Rehabilitate.

DECATUR
WELLNESS & REHABILITATION CENTER

March 24, 2023

Mr. Logan Grant
Tennessee Health Facilities Commission
500 Deaderick Street
Nashville, TN

RE: ***Approval for New* Hospice *Program by Heritage Hospice***

Dear Mr. Grant:

I am the Operator of Decatur Wellness and Rehabilitation Center. We are the only skilled nursing facility in Meigs County. Our mission is to serve the residents of Meigs and adjacent counties. Our facility has 88 licensed beds. We serve both short and long term patients. The largest source of our admissions is Meigs County residents, but we have admissions from McMinn, Rhea and Hamilton Counties, among others. Operating within, and serving, rural counties we believe that on occasion area residents may have hampered access to end of life hospice services.

I have had the opportunity to learn about Heritage Hospice. It is my understanding they have conducted specific research of this region and determined it to be underserved relative to end-of-life care which is consistent with our observations regarding hospice care in general and hospice for minorities.

My understanding about Heritage Hospice and how it will make a difference in our service area includes the following:

- Be Medicaid certified to accept any Medicaid clients
- Admit any qualifying hospice patient even if a charity care patient

- Admit patients during both day and night, including weekends to enable family participation after work or days off
- Educating our professional staff on palliative and hospice care resources and how to incorporate into our treatment plans when appropriate
- Assist our facility in educating the community regarding end of life care
- Providing spiritual support for patients and families

Please approve Heritage Hospice as it will address a specific hospice program need in our area that to date has not been met by the existing providers in this region.

Decatur Wellness and Rehabilitation Center will work with Heritage Hospice to address the needs of our terminally ill patients including collaborating with them on hospice services in our facility and the additional commitments they have outlined which are identified above. Based on our patient profile, I would expect at least one referral per month from our facility and additional referrals from our physician.

Thank you for your consideration of my input and we look forward to working with Heritage Hospice upon its CON approval.

Regards,

Managing Member

Soddy-Daisy
HEALTHCARE CENTER

March 22, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
500 Deaderick Street
Nashville, TN

RE: HERITAGE HOSPICE CERTIFICATE OF NEED APPLICATION

Dear Mr. Grant:

I am the Administrator of Soddy Daisy Healthcare Center. We are a 134-bed licensed nursing home located in Hamilton County at 701 Sequoyah Road, Soddy Daisy. Residents in our home are primarily from Hamilton County and surrounding communities. About half of our patients are TennCare recipients with the remainder being Medicare and other payors.

As part of the Hamilton County healthcare infrastructure, we are very familiar with the range of services available to the region's population. The diversity of Hamilton County is well known, with approximately 18 percent of the population being black and an additional 6 percent being Hispanic. With our experience, we have observed that the minority population accesses important end of life hospice care at a lower rate than the rest of the population. This happens within our community and we understand it occurs elsewhere as well.

Heritage Hospice is seeking certificate of need approval to establish a hospice to specialize in reaching the black population and enhancing their appropriate use of hospice care. We believe this is an important element that is much needed in Hamilton County. The black population has been disadvantaged with healthcare access and Heritage Hospice is focused on providing services to this underserved population group.

Given Heritage Hospice's programming, I am strongly advocating for the Tennessee Health Facilities Commission to approve the Heritage Hospice CON application to provide hospice services for the black population and other persons in our region of the state.

With Heritage Hospice's approval, I would expect between our facility physicians and our discharge planners to refer at least two patients per month to Heritage Hospice. They will be able to have their end of life needs met by this provider. I will also contract with Heritage Hospice to meet the needs of my patients/families at Soddy Daisy Healthcare Center.

Sincerely,

Ray Allen RN LNHA
Administrator

Charter
SENIOR LIVING
of Cleveland

Pamela Turley, RN
Executive Director
Main: 423-614-5424
Cell: 423-316-2125
ed@chartercleveland.com
2900 Westside Drive, N.W.
Cleveland, TN 37312

chartercleveland.com

March 22, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
500 Deaderick Street
Nashville, TN

RE: HERITAGE HOSPICE CERTIFICATE OF NEED APPLICATION

Dear Mr. Grant:

I am the Administrator at Morningside of Cleveland. We are a small close knit, licensed skilled nursing facility, 2900 Westside Dr, N.W., Cleveland, Bradley County. As a Charter Senior Living Community, we have a stellar reputation for providing the highest quality senior living. Our facility provides both short and long term care.

I understand that Heritage Hospice is submitting a Certificate of Need application to address the fact that the black population is underserved in general, and more specifically with respect to end of life hospice care. I met with Heritage Hospice representatives and believe they have the ability to lift up the minority hospice penetration in southeast Tennessee. This will add tremendous value to the residents of our service area as existing providers have been unable to minimize the disparity in hospice utilization amongst differing races.

Unlike the existing providers, Heritage Hospice has a culturally competent strategy to address disparities in minority populations, particularly with respect to the Black and Hispanic populations. This strategy will be deployed in our service area which will be an invaluable resource where it is proven that both Blacks and Hispanics receive lesser hospice services than the general population. Heritage Hospice, if approved, will augment hospice utilization for these minority groups through education on end of life care, comprehensive outreach and specifically tailored programs to enhance minority hospice utilization.

Once approved and licensed, I expect to work with Heritage Hospice in our community, enabling them to educate our residents, families, and others. I would also anticipate them working with our medical director and case managers in assessing our residents likely resulting in a couple of referrals per month.

Heritage Hospice will be a great resource for our residents and a wonderful addition to our local healthcar landscape. I hope that in evaluating the need for a hospice to address healthcare disparities in the blac population of this service area, you will agree that Heritage Hospice's CON application should be approved.

Thank you for your consideration.

Sincerely,

Pam Turley, RN
Administrator

March 24, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
500 Deaderick Street
Nashville, TN

RE: CON Application for Heritage Hospice

Dear Mr. Grant:

I am the Administrator at The Lantern Alzheimer's Center At Morning Pointe. We are a 42-bed licensed Assisted Care Living Facility, 9300 Messinger Lane Ooltewah, Hamilton County Tennessee. At The Lantern Alzheimer's Center At Morning Pointe, we know that Alzheimer's and other forms of memory loss can make life difficult for seniors and their families. We designed our community to provide families with specialized memory care services to support them as they go through the challenges of memory loss. We care for every resident in a structured, home-like environment to help them feel safe and secure. So, it only makes sense that we offer the same in hospice care.

I understand that Heritage Hospice is submitting a Certificate of Need application to address the fact that the black population is underserved in general, and more specifically with respect to end of life hospice care. I met with Heritage Hospice representatives and believe they have the ability to increase the minority hospice penetration in our community. This will add tremendous value to the residents and our communities, as existing providers have been unable to minimize the disparity in hospice utilization amongst different races.

The diversity of Hamilton County is well known, with approximately 17 percent of the population being black and an additional 8 percent being Hispanic. We understand the lack of access to hospice care in our community and believe this to be the same in other surrounding communities.

I had the opportunity to meet with Heritage Hospice to review their strategy to meet the needs for the terminally ill minority population. I believe there is a lack of awareness of hospice services which puts them at risk of dying without end-life care. In reviewing Heritage Hospice's plan it will decrease the lack of hospice education services through their quality education outreach.

Given Heritage Hospice's approach, I am strongly advocating for the Tennessee Health Facilities Commission to approve the Heritage Hospice Certificate of Need Application to provide hospice services for the black population and other persons in our region of the state.

Thank you for allowing me this platform in a show of support for Heritage Hospice's efforts to establish a new hospice program.

With Regard,

Larry Griffin
Executive Director

Larry Griffin
Executive Director

THE
Lantern
at Morning Pointe
Alzheimer's Center of Excellence
COLLEGEDALE

9300 Messinger Lane
Ooltewah, TN 37363
collegedale-lan-ed@morningpointe.com
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423-396-4700
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Fax; 423-396-4722

April 18, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
665 Mainstream Drive
2nd Floor
Nashville TN 37243

RE: Heritage Hospice Certificate of Need Application

Dear Mr. Grant:

I am the Executive Director of Brookdale Mount Vernon Drive, located in Cleveland Tennessee. It is a 30-bed Assisted Living Facility. I understand that Heritage Hospice is looking to provide hospice services in our service area. Our community will benefit from an additional hospice provider, and Heritage is an ideal provider to fulfill the gap in hospice services.

Recently, I had the pleasure of meeting with Tywanna Hamilton, President of Heritage Hospice and learned about their efforts to increase hospice accessibility within the minority population if their Certificate of Need Application is approved. I understand that Heritage Hospice is seeking to provide hospice services in our community which will definitely benefit from an additional hospice provider.

In addition to working to reach the minority population their increased service intensity is impressive, and Heritage Hospice has a focused program to enroll patients in hospice care, targeting a reduction in the gap of services and enhancing access to hospice.

Brookdale is looking forward to the opportunity to coordinate end-of-life care with Heritage Hospice for our terminally ill residents should they be awarded the Certificate of Need to establish a hospice in our community. We look forward to a positive working relationship with Heritage Hospice upon their approval.

Thank you for allowing me to provide input into the Certificate of Need decision.

Sincerely,

Wendy Owens

Wendy Owens
Executive Director

BROOKDALE
SENIOR LIVING

Wendy Owens
Executive Director

Main (423) 473-7300
Mobile (423) 599-6513 | Fax (423) 472-8307
wowens@brookdale.com

April 4, 2023

Mr. Logan Grant
Executive Director
Tennessee Health
Facilities
Commission 665
Mainstream Drive
2nd Floor

RE:

Hospice Certificate of Need Application | Heritage Hospice

Dear Mr. Grant:

I am the Executive Director of Dominion of Hixson. The Assisted Living is located in Hamilton County We are a 64 bed Assisted Living Facility, and it's my understanding that Heritage Hospice is proposing a new hospice program in our community. I have had the opportunity to discuss Heritage Hospice's proposal and believe it will be an outstanding service provider addition in Hamilton. County.

I have reviewed the information on Heritage Hospice's cultural programs and increased service intensity and am a strong advocate for this service I look forward to Heritage Hospice to increase hospice accessibility within our community.

Heritage Hospice has shared with me their plan to increase the African- American and Latino population in our area by enhancing access to hospice services through education, relationship building and high quality services in the person's home.

To enhance the quality of services and bridge the gap in hospice accessibility in our community, please approve Heritage Hospice's proposal to establish a new hospice in Hamilton County.

Sincerely,

Cody Workman

Executive Director

Honoring
God Through
Service to
Seniors

Cody Workman
Executive Director

o. 423-847-2646
c. 760-805-6090
f. 423-475-5508

CodyW@DominionHixson.com

DominionSeniorLiving.com/Hixson

2143 Northpoint Blvd
Hixson, TN 37343

April 19, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
500 Deaderick Street
Nashville, TN

RE: HERITAGE HOSPICE CERTIFICATE OF NEED APPLICATION

Dear Mr. Grant:

Recently, I had the pleasure of meeting with the President of Heritage Hospice and learned about their initiatives they plan to implement if approved to establish a new hospice service in Southeast Tennessee. Our County will definitely benefit from an additional hospice provider.

I am the Resident Services Director of Garden Plaza At Cleveland, located in Bradley County Tennessee, the thirteenth most populous county in Tennessee. Garden Plaza was recently named U.S. News best Senior Living community. The ratings are based on such factors as community and activities, food and dining, caregiving and management, and staffing for nearly 2,500 communities in the continental U.S. and Hawaii.

I understand that Heritage Hospice is submitting a Certificate of Need application to address the fact that the black population is underserved in general, and more specifically with respect to end of life hospice care. I met with Heritage Hospice representatives and believe they have the ability to lift up the minority hospice penetration in southeast Tennessee. This will add value to the residents of our service area as existing providers have been unable to minimize the disparity in hospice utilization amongst differing races.

Unlike the existing providers, Heritage Hospice has a culturally competent strategy to address disparities in minority populations, particularly with respect to the Black and Hispanic populations. This strategy will be deployed in our service area which will be an invaluable resource where it is proven that both Blacks and Hispanics receive lesser hospice services than the general population. Heritage Hospice, if approved, will augment hospice utilization for these minority groups through education on end of life care, comprehensive outreach and specifically tailored programs to enhance minority hospice utilization.

Once approved and licensed, I expect to work with Heritage Hospice in our community, enabling them to educate our residents, families, and others. I would also anticipate them working with our medical director and case managers in assessing our residents likely resulting in a couple of referrals per month.

Heritage Hospice will be a great resource for our residents and a wonderful addition to our local healthcare landscape. I hope that in evaluating the need for a hospice to address healthcare disparities in the black population of this service area, you will agree that Heritage Hospice's CON application should be approved.

Sincerely,

Brittany Sinclair

Brittany Sinclair
Resident Services Director

Brittany Sinclair
Resident Care Director
bsinclair@centurypa.com

GARDEN PLAZA
AT CLEVELAND
A CENTURY PARK COMMUNITY
www.gardenplazaatcleveland.com

3500 Keith Street NW
Cleveland, TN 37312

Phone: 423.479.4447
Fax: 423.961.6502
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American House
SENIOR LIVING COMMUNITIES
Shallowford
4233943449

AARON PERRY
Executive Director

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7127 Lee Highway
Chattanooga | TN | 37421

shallowford@americanhouse.com
AmericanHouse.com

March 22, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
665 Mainstream Drive
2nd Floor
Nashville, TN 37243

RE: Certificate of Need Application for Heritage Hospice

Dear Mr. Grant,

American House Shallowford is a 66-bed Assisted Living Facility located in Hamilton County Tennessee, offering high quality housing for seniors. That vision of excellence has endured for more than 40 years and expanded to serve residents at a number of senior housing communities. At American House our mission statement is "Living well is Being Well. This drives everything we do". Our vision is to be an innovative senior housing organization that creates sustainable excellence and stakeholder value, with an unparalleled commitment to compassionate care provided by passionate people, which is why I support Heritage Hospice's efforts to establish a hospice in our community.

In meeting with the Heritage Hospice leadership, I learned our passion to serve the community was the same. Heritage Hospice seeks to be awarded the Certificate of Need to establish a new hospice. I believe Heritage Hospice is the best applicant to fulfill the need with the focus on increasing hospice accessibility within the minority population.

We are impressed with Heritage Hospice's focus to enroll patients in hospice care, targeting a reduction in the gap of services and enhancing access to hospice.

Even with the current hospice providers in our community, it's clear they are a hospice with a personal touch.

I look forward to working with Heritage Hospice and having my terminally ill residents capitalize on that 'personal touch' upon approval.

Thank you for allowing me to provide input into the Certificate of Need decision.

Kind regards,

Aaron Perry
Executive Director

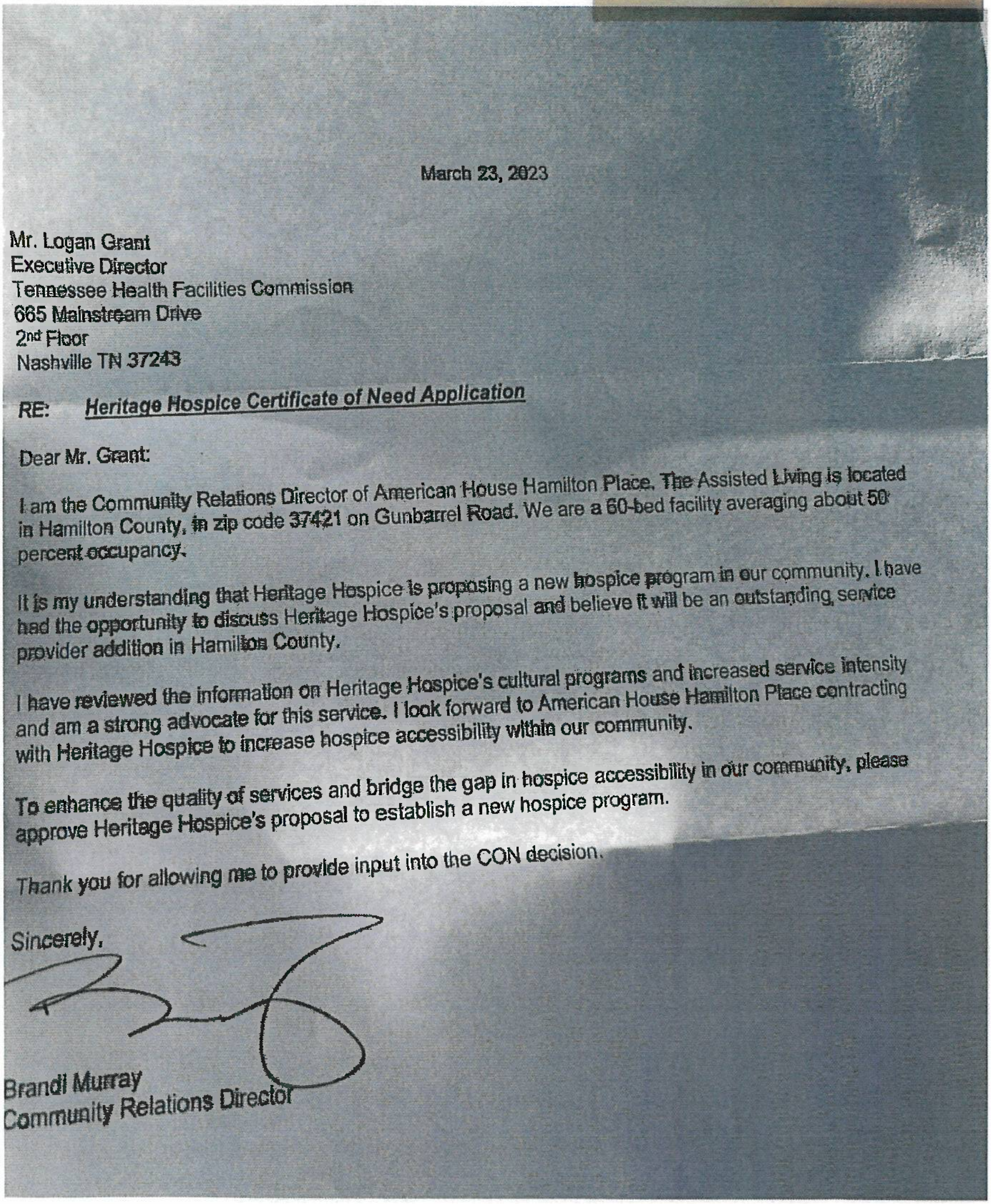
American House
SENIOR LIVING COMMUNITIES
Hamilton Place

BRANDI MURRAY
Community Relations Director

T 423 485 9496
C 423 362 3680

1502 Gunbarrel Road
Chattanooga | TN | 37421

hamiltonplacesales@americanhouse.com
AmericanHouse.com



March 23, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
665 Mainstream Drive
2nd Floor
Nashville TN 37243

RE: ***Heritage Hospice Certificate of Need Application***

Dear Mr. Grant:

I am the Community Relations Director of American House Hamilton Place. The Assisted Living is located in Hamilton County, in zip code 37421 on Gunbarrel Road. We are a 60-bed facility averaging about 50 percent occupancy.

It is my understanding that Heritage Hospice is proposing a new hospice program in our community. I have had the opportunity to discuss Heritage Hospice's proposal and believe it will be an outstanding service provider addition in Hamilton County.

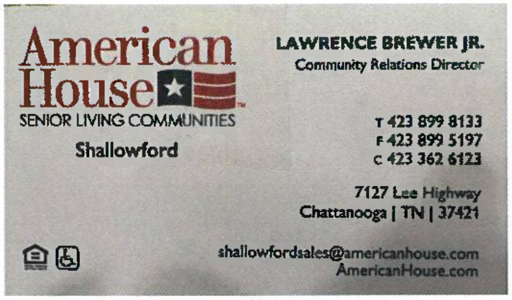
I have reviewed the information on Heritage Hospice's cultural programs and increased service intensity and am a strong advocate for this service. I look forward to American House Hamilton Place contracting with Heritage Hospice to increase hospice accessibility within our community.

To enhance the quality of services and bridge the gap in hospice accessibility in our community, please approve Heritage Hospice's proposal to establish a new hospice program.

Thank you for allowing me to provide input into the CON decision.

Sincerely,

Brandi Murray
Community Relations Director



American House
SENIOR LIVING COMMUNITIES
Shallowford

LAWRENCE BREWER JR.
Community Relations Director

T 423 899 8133
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C 423 362 6123

7127 Lee Highway
Chattanooga | TN | 37421

shallowfordsales@americanhouse.com
AmericanHouse.com

June 27, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
665 Mainstream Drive
2nd Floor
Nashville TN 37243

RE: Hospice Certificate of Need Application | Heritage Hospice

Dear Mr. Grant:

I am the Community Relations Director of American House Shallowford Place. The Assisted Living is located in Hamilton County. We are a 66-bed Assisted Living Facility.

It is my understanding that Heritage Hospice is proposing a new hospice program in our community. I have had the opportunity to discuss Heritage Hospice's proposal and believe it will be an outstanding service provider addition in Hamilton County.

I have reviewed the information on Heritage Hospice's cultural programs and increased service intensity and am a strong advocate for this service. I look forward to American House Shallowford Place contracting with Heritage Hospice to increase hospice accessibility within our community.

Heritage Hospice has shared with me their plan to increase the African-American and Latino population in our area by enhancing access to hospice services through education, relationship building and high quality services in the person's home. We will support their efforts by referring 2-3 appropriate residents per month.

To enhance the quality of services and bridge the gap in hospice accessibility in our community, please approve Heritage Hospice's proposal to establish a new hospice program.

Sincerely,

Lawrence Brewer Jr.

Lawrence Brewer Jr
Community Relations Director

ATTACHMENT 1N-5

Charity Care Policy

CHARITY CARE

Policy No: 1036

PURPOSE

To identify the criteria to be applied when accepting patients for charity care.

POLICY

Patients without third-party payer coverage and who are unable to pay for medically necessary care will be accepted for charity care admission, per established criteria.

Heritage Hospice will establish objective criteria and financial screening procedures for determining eligibility for charity care.

The organization will consistently apply the charity care policy.

Effective	Reviewed	Revised
05-01-2023		

PROCEDURE

1. When it is identified that the patient has no source for payment of services and requires medically necessary care/service, the patient must provide personal financial information upon which the determination of charity care will be made.

2. A social worker, as available, will meet with the patient to determine potential eligibility for financial assistance from other community resources.

3. The Program Director/Administrator will review all applicable patient information, including financial declarations, physician (or other authorized licensed independent practitioner) orders, initial assessment information, and social work notes to determine acceptance for charity care. It is then forwarded to the Chief Operating Officer who will make the final determination of acceptance.

4. All documentation utilized in the determination for acceptance for charity care will be maintained in the patient's billing record.

5. When financial declarations reveal the patient is able to make partial payment for services, the Program Director/ Chief Operating Officer will determine the sliding-fee schedule to be implemented.

6. The revised sliding-fee schedule will be presented to the patient for agreement and signature.

7. After acceptance for charity care, the patient's ability to pay will be reassessed every 60–90 days.

8. When the organization is unable to admit the patient or to continue charity care, every effort will be made to refer the patient for appropriate care/service with an alternate provider.

9. The referral source will be advised of acceptance, non-acceptance, continuation, or discharge from charity care.

ATTACHMENT 1N-6

Leadership Resources

Tywanna Hamilton

Resume'
McCalla, AL 35111
Tywannahamilton72@gmail.com
+1 205 962 5484

I am a dedicated, team oriented and respectful person. I strive for excellence with any task I encounter.
I believe that excellent customer service is my most important accomplishment.
I am looking for an opportunity to work in a family environment with dedicated and team oriented individuals.
I have accomplished so much during my tenure as a nurse and now I'm pursuing new challenges.

Authorized to work in the US for any employer

Work Experience

President

Heritage Hospice - Tennessee
March 2023 to Present

Acquisitions
Business Development
Finance
Strategic Planning
Hiring Manager
Compliance
Clinical reviews and oversight
Growth Planning

Regional Administrator

(Homestead hospice)Traditions Health
May 2022 to March 2023

I'm responsible for the day to day operations.
Budget projections
Financial stability(creating new business opportunities, managing EBITDA & my budget-PPD expenses.)
Growth and Development (identifying cohesive networking opportunities, strategic analysis, development of long term business plans, contract negotiations with C-Suites, Metrics analysis, identifying and developing a diverse Sales team, diverse patient mix)
From 6/22 to present my branches have brought in 58 1st benefit patients. Manage SHP & CAHPS prevention. Recovery calls monthly.
My branches are financially stable with over $1 million in revenue within the last 4 months.
I hire qualified professionals for the back office, Clinical & Spiritual team. I coordinate volunteer services and promote branding.

Administrator

HOMESTEAD HOSPICE - South AL

March 2021 to May 2022

I am responsible for the day to day Operations and Business Development.
Hiring & training qualified Ops & Business Development staff
Seek C-Suite accounts
Contract negotiations with potential cohesive partnerships.
Effective conflict resolution
Payroll, Financials
Provide a sound structured program
Securing an optimal patient mix
Effective delegation, excellent customer service & staff oversight
Oversight of IDG, MD collaboration
Reports, Accounts Payable

maintain budgeted EBITA & NOI

VP Sales & Marketing, Consultant

Humbled Beginnings - Atlanta, GA
October 2016 to March 2021

I'm responsible for identifying a stable book of business consisting of 80 viable referral sources.

- maintain a healthy relationship with hospital and rehab discharge planners, ALF, physician practices, Clinics and Senior Living Communities.
- provide warm transfers to all my referrals by ensuring the client is familiar with home health criterion's, homebound status & home health expectations.
- order all DME & ensure its readily available on discharge.
- obtain any orders needed. I make sure the family home health experience is a delightful memory.
- My responsibility is to make sure the company I represent core values are met to the fullest with every person I encounter.
- act as a mediator when a referral source experience a service issue. My responsibility is to address the issues timely, work with the Clinical Supervisor to identify an optimal/measurable solution.
- provide presentations to prospective sources and co market with Hospice companies that will provide inservice and CEUs.
- foster partnerships with companies that have the ability to help brand and build the company.
- Coordinate activities within the Senior communities
- Develop a familia environment between both companies
- search out C Suite opportunities...
- I currently have 5 communities averaging 690 potential clients.
- Partnered with other companies to position the company as the Preferred provider in 4 LTACs, 5 Senior Living communities and 3 physician practices in Alabama. Multiple partnerships in the GA region. 2 cohesive partnerships in Kentucky.
- seek out Medical providers to assist in growth
- Adjust target census in accordance with necessary Ops/Clinical needs
- average 30-35 PPS Referrals monthly
- exceeded my 2017 annual target census of 275 PPS admissions.

Starting census 3 Oct 2016
2018 active PPS census 150

2020, I have established the company with stable business partnerships in 3 States.

- Met target within 18 months

Train Business Development team
2018-2020

VP of Clinical Services

- Implementation of Clinical Policies & Procedures
- Quality Assurance
- Hire, Train & Develop Clinical Directors
- Ensure Company adheres to all State Requirements

.Work diligently with the Operations & Business Development Team to secure and maintain contracts through quality services.

- Risk Management

. Monthly review of Clinical outcomes & patient satisfaction.
. Conflict resolution

- Provide Consultations & resolutions in Crisis communities

Operations (Setting realistic budgets with Realistic approach, Management review, HR reviews and Compliance)
Business Development
(Forecasting, Marketing strategies, Networking, Budgets and Effective Closing)
Clinical
(Compliance, QA, Risk Management, Mock Surveys, Leadership and Budget maintenance)

Business Development (Contractor)

Intrepid USA Healthcare Services - Birmingham, AL
June 2016 to September 2016

*To establish a strong book of business
*Open opportunities for new business and cohesive networking opportunities
*Obtain face to face with referrals
*Attend weekly clinical meetings
*Search and identify C-Suite accounts
*Coordinate transfer to home
*Participate and Coordinate activities within the Senior communities
*Be a mediator between Clinical team and Referral sources
*Ensure each referral source understand the criteria for home health.
My primary focus are Physician groups. My task is to bring them to the forefront for referring vs waiting on a patient to be hospitalized before the service is offered.
Goal: For MDS to understand the importance of being proactive vs reactive which saves lives and improves Health care.

Business Development Director (Contractor)

Arcturus Hospice and Palliative Care - Atlanta, GA
May 2016 to September 2016

My responsibilities include

- networking (Established 4 strong referral sources)
- initiating, negotiating and securing new contracts
- implementing effective marketing strategies
- securing new business
- meeting projected target census

- employing sales team members
- weekly sales calls,*negotiating contracts/business agreements,
- employee evaluation
- metric reports
- Develop business plans
- Staff training.

Palliative Care Consultant

HOSPICE ADVANTAGE-Hospice Compassus - Atlanta, GA
October 2015 to April 2016

Responsibilities
I develop, maintain and grow a network of repeat hospice care referral sources within my assigned territory.
I communicate with families to explain services and programs available.
Input referrals in PCC notebook
Provide community inservice

Accomplishments
I average 3-4 referrals weekly.

Skills Used
Exceptional interpersonal skills

DON/Executive Director

Dunwoody - Atlanta, GA
December 2013 to July 2015

Responsibilities:
Director of Nursing:
I am responsible for the Wellness department & Assisted Living.
Duties include:
staffing, assessing prospects and current residents, hiring staff, conducting inservice & family meetings, managing the incontinence program and training the staff.
Medication administration and supervision.
Triage and application of the nursing process to ensure appropriate and timely nursing intervention are executed.
Staff evaluations and supervision.
Chart audits and documentation.
Resident assistance and timely response to family concerns.
Teaching residents about disease processes and disease management to inject them into the care process needed to maintain a healthy lifestyle.
Implementing marketing strategies and research with a focus on marketing mix. Community remained at 100% census.
Accomplishments
In my time here, I have decreased hospitalizations & falls 90% within a 30 day period. This was accomplished by adequate staff training & promoting staff awareness and injecting outside vendors such as Home Health/ Hospice as needed. I have maintained the budget and increased the communities revenue within my first 30 days of assuming the ALD position.

I have implemented a home care program that has increased our revenue by 50,000 monthly, also $10,000 revenue increase for the incontinence program.
I have employed and trained a very diverse and knowledgeable team to continue this success. There has been a significant decrease in family/resident complaints due to our consciousness in regards to customer service.
EXECUTIVE DIRECTOR:
. Met projected NOI & Revenue consistently
. Managed Capital expenses
. Deficiency free Surveys
. Provided effective oversight of the Leadership team
. Risk Management
. Effective communication with the Governing Body & Support team
. Maintained a Customer Service friendly environment
. In-services
. Marketing Strategies (strong closer)
. Leasing contracts
. Tours
. Cold calls & follow up calls (indecisive prospects)
. Effective team building and staff retention

Skills Used

I have strong leadership skills and an acquired knowledge base for clinical appropriateness. I am able to assess/evaluate timely and provide appropriate nursing interventions in a timely manner.

Clinical Manager Assistant/Ops Specialist

Amedisys - Atlanta, GA
January 2013 to December 2013

Responsibilities
* responsible for chart audits, reviewing and inputting verbal orders into the que, care coordination, assessments, wound care, assistance with planning treatment, MD collaboration, ordering DME, review and lab follow up, scheduling, inservice, retrieval/ managing face to face, retrieving signed MD orders. I occasionally work in the field when needed.

Accomplishments
I was responsible for our office financial rank improvement by recovering outstanding orders and face to face.
I recovered millions in lost revenue during my last 6 months of employment as Operations Specialist.
My responsibility was to create a spreadsheet to monitor outgoing services/projected income versus received income. Identify methods of retrieval.

Wellness Coordinator

Sunrise Senior Living - Atlanta, GA
August 2012 to January 2013

My responsibilities:
I was responsible for ensuring appropriate, accurate and quality clinical care was provided to each resident with dignity and respect.

Chart audits, medication reconciliation and audits, family meetings, documentation, MD collaboration, home health/hospice consults, Med Tech training and inservice.
Effective communication with Executive Director, Assisted Living Director, Reminiscent Coordinator and the Healthcare Coordinator.

ADON-Executive Director

Atrium Senior Living & Transitional Care
January 1997 to August 2012

I was responsible for all clinical aspects and the financial. I coordinated & provided care for mechanical dependent vent patients, status post surgical patients, infectious disease, general med surge, rehab, long term care and our Assisted Living Residents in a dignified & respectful environment. I performed mock surveys to ensure that the clinical staff was prepared to pass State & federal surveys. I initiated a clinical preparedness program which has been accepted & utilized at all 10 facilities with a 92% pass rate during the last 8 yrs, however, my facility had been deficiency free for 8 years(2004-2012). I was a proud member of a successful team of dedicated, highly motivated & caring individuals.
As Executive Director, I ensured our community operated within budget: Department Heads managed their VCB, kronos(hours/schedules & OT) weekly; ordered supplies from approved vendors, participated in community outreach, ensured the community remained at high occupancy. I ensured customer service satisfaction was understood and embraced by all employees, that all staff received proper training to be effective in their roles. I am fair and honest with staff. I encourage everyone to be their very best each day and strive to make a difference in a life daily(resident, family members or co workers).

LPN-PRN

Gentiva Health Services - Birmingham, AL
March 2008 to March 2010

Responsibilities
I performed clinical duties in a home setting:enteral feedings/teaching, lab draws, medication & disease process teaching, wound care(wound vac, measurements), assessments, MD collaboration, Foley insertion and maintenance.

Accomplishments
I provided excellent care as evidence by reduction in rehospitalizations.

Skills Used
phlebotomy, nursing process and critical thinking

LPN-prn

Maxim health care - Birmingham, AL
February 1997 to August 2006

I administered medications, provided wound care, restorative nursing, medicare documentation, labs, enteral feedings, observation & assessments, trach care & MD collaboration, Staff supervision, scheduling & infection control.

Education

LPN in Nursing

Lawson State - Bessemer, AL

1995 to 1996

Bachelor's degree in Economics
Northwestern University
May 1993 to June 1994

Bachelor's degree in Economics
UAB - Birmingham, AL
August 1991 to May 1993

Skills

- Management crisis (10+ years)
- Sales And Marketing (5 years)
- Cold Calling
- Business Development
- B2B
- Account Management
- CRM
- Sales
- Data Entry
- Salesforce
- MS Office
- Quickbooks
- Powerpoint
- Inventory Management
- Receptionist
- Business Intelligence
- Excel
- Infection Control Training
- Contract Negotiation
- Program Management
- Kronos
- Triage
- Performance management
- Management
- Microsoft Office

Certifications and Licenses

LPN

driver's license

Category 2 Assisted Living Administrator

Compact Licensing (LPN)
Present

LVN

CPR Certification

Quality Assessment and Performance Improvement Plan (Sample)

SAMPLE QAPI PLAN

SAMPLE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PLAN

MISSION

All QAPI activities must support and be aligned with the mission of the organization.

The mission of the hospice is to provide compassionate, high quality healthcare for the best value, one person at a time, in their home setting.

To carry out this mission, the hospice provides:

- A holistic program for the patient and family, caring for the physical, psychological and rehabilitative needs
- A dedicated team of health care professionals and staff who are qualified by experience and education
- Education to families, caregivers, and the community at large in the areas healthcare and chronic disease management in the home setting

PURPOSE

The purpose of the hospice QAPI Plan is to provide a strategy for the systematic organization-wide implementation of quality assessment and performance improvement activities. This will ensure that the organization is providing appropriate, high-value, effective and efficient services in accordance with its mission and current standards of practice. Through QAPI activities, the organization provides a mechanism for identification and prioritization of opportunities for problem identification and improvement in care and operations.

OBJECTIVES

- To show measurable improvement in indicators that demonstrate an improvement in patient outcomes
- To measure, analyze and track quality indicators, including adverse events, to enable the assessment of processes of care, hospice services and operations
- To collect data to monitor the effectiveness and safety of services and quality of care as well as to identify opportunities for improvement
- To conduct Performance Improvement Projects aimed at performance improvement and to track performance to ensure that it is sustained

- To document QAPI activities including reasons for Performance Improvement Projects and progress achieved on these projects

- To keep current with monitoring of required quality measures; submit reports in mandated format within required timeframes

METHODOLOGY

The QAPI Plan is operated through a committee structure that ensures that the QAPI program follows regulatory requirements. The QAPI Coordinator ensures that leadership priorities for improvement are evaluated. In addition, the QAPI Coordinator examines results from ongoing quality control activities to identify trends that will need follow-up action by the QAPI Committee.

The methodology selected to support and facilitate improvement activities is based on the Plan-Do-Study-Act (P-D-S-A) model. When an action for improvement is identified, an individual or project team may be designated to pilot the recommended action. A timeframe is established for implementing and evaluating the piloted action's outcome.

The effectiveness of any action will be assessed through a process that measures whether the performance expectations outlined in the action plan have been met. This may require additional data collection and analysis. Statistical analysis will be used in assessing performance outcomes.

ASSIGNMENT OF RESPONSIBILITY

Resources will be made available to employees to assist them in gaining a basic understanding of QAPI principles. Inservices will be held periodically to reinforce the knowledge base. Each employee is responsible for the quality of care and services provided. The following summary of responsibilities provides a framework for the process of quality assessment and performance improvement.

The Governing Body is ultimately responsible for the QAPI Plan and for ensuring:

- That the QAPI Plan is ongoing, implemented and maintained

- That implemented QAPI activities address the appropriate priorities for the improved quality of care and patient safety

- Clear expectations for patient safety are met

- That all QAPI actions/changes are evaluated for effectiveness

- The QAPI Plan meets regulatory requirements

RESPONSIBILITIES OF QAPI COORDINATOR

The QAPI Coordinator chairs the QAPI Committee and is responsible for coordinating and facilitating all quality improvement activities. This includes, but is not limited to:

- Ensuring the collection of accurate and reliable data
- Participating in cross-organizational activities to assess and improve overall organizational quality and performance
- Assisting in the implementation of corrective actions as appropriate
- Evaluating the effectiveness of planned and implemented actions
- Encouraging staff participation in improvement activities by mentoring; advancing education by acting as a resource to all staff
- Aggregating, trending and analyzing data using appropriate statistical techniques
- Ensuring timely data submission of required quality measures
- Reporting significant findings to appropriate managers, staff and governing bodies

RESPONSIBILITIES OF QAPI COMMITTEE

The QAPI Committee is responsible for evaluating and prioritizing QAPI activities based on the aggregation of analysis of data collected. The QAPI Committee has the authority to issue recommendations for action or further study. Under the direction of the QAPI Coordinator, the committee issues a quarterly report summarizing QAPI activities and results of actions taken. The report is submitted to the Governing Body and appropriate managers and staff.

QAPI Committee members are appointed for staggered one-year terms that are renewable for a second term. The committee includes representatives from the following areas:

- Administration
- Clinical management
- Business office/billing/admitting
- Medical records
- Nursing
- Therapies (PT, OT, SLP)
- Dietitian or nutrition counselor
- Medical director or designee

- Support services
- Contracted services
- Medical social services
- Pharmacist, as needed

Department managers and supervisors are responsible for providing leadership to ensure the communication and coordination of QAPI activities. Managers are responsible for initiating immediate corrective action if problems identified threaten the safety of patients or staff. Additionally, they are responsible for participating in the QAPI Committee when assigned and identifying opportunities for improvement through their daily interactions.

Clinical and office personnel are responsible for participating in identifying opportunities for improvement through their daily contact with patients, physicians and other employees. Staff may be requested to participate in the QAPI Committee or specific team activities such as data collection, analysis, action planning and implementation of new or improved processes as needed.

EVALUATION OF THE QAPI PLAN

A formal evaluation of all QAPI activities will occur annually. A written report will be completed by the QAPI Coordinator. After review by the directors of each department, the report will be presented to the Governing Body. The report will include a summary of all activities included as part of the QAPI Plan. The Governing Body will measure the effectiveness of the QAPI Plan based on the established objectives. The Governing Body will provide input into the identification and prioritization of future improvement activities.

CONFIDENTIALITY

The QAPI Coordinator maintains all QAPI-related records in a secure storage area (physical area or HIPAA compliant electronic storage). Completed unusual occurrence/incident/adverse event reports are maintained by the administration. Any requests for results of or data from the QAPI Plan will be forwarded to the designated administrator, who will respond only according to the organization's policy and procedure.

THE QAPI PLAN – DISCUSSION

This QAPI Plan is effective because the QAPI efforts are grounded in the mission of the organization. The approach is a multi-disciplinary and collaborative one, and specific areas of responsibility are outlined.

This QAPI Plan is founded on basic QAPI principles. It demonstrates that everyone in the organization is involved through their participation in a variety of QAPI activities. In order to accomplish this, the leaders provide education, resources in QAPI principles, and time to participate in QAPI activities.

The improvement methodology is identified to ensure a systematic approach to improvement efforts. There is a provision in the QAPI Plan to evaluate the effectiveness of the QAPI activities.

This QAPI Plan demonstrates leadership involvement throughout the process. The Plan allows the flexibility needed if new problems or opportunities take priority.

Policy and Procedures:

Admission Process
Initial/Comprehensive Assessment
Intake Process
Scope of Services
Coordination of Care/Service
Interdisciplinary Team (IDT) Meeting
Interdisciplinary Team Plan of Care
Nursing Services
Spiritual Services
Bereavement Services
Admission Guidelines for Inpatient Services
Admission for Respite Care
Continuous Care Services
Improving Organizational Performance

ADMISSION PROCESS

Policy No: 2002

PURPOSE

To establish the process and procedure for evaluation and admission of patients into hospice or referral to another more appropriate agency

POLICY

Patients are accepted for hospice care on the basis that the patient meets all admission criteria and that there is a reasonable expectation that the patient's needs can be adequately met by Heritage Hospice in the patient's place of residence.

Effective	**Reviewed**	**Revised**
05-01-023		

ADMISSION PROCESS
Policy No: 2002

PROCEDURE

1. Patients 18-years or older (individual sites may admit pediatric/adolescent patients when there is available staff knowledgeable of the specialized care necessary) will be accepted for care if the following criteria are met:
   (a) The patient must be under the care of a physician who will order and approve the provision of hospice care, sign a Certificate of Terminality and be willing to sign or who has a representative who will sign a death certificate.
   (b) The patient may identify a family/caregiver or legal representative who agrees to be a primary support care person if and when needed. **In the State of Delaware, a primary caregiver must be named.**
   (c) The patient has a life-threatening illness as determined by the attending physician and the hospice Medical Director.
   (d) The patient/family desire hospice services and is aware of the diagnosis and prognosis.
   (e) The focus of the care desired will be palliative, not curative.
   (f) The patient must have a prognosis of six months or less if the disease takes its normal course.
   (g) The patient/family agree to hospice care and will participate in the plan of care and sign the consent form and Election of Hospice form.
   (h) The patient/family/caregiver agrees that the hospice care will be provided primarily in the home.
   (i) The physical facilities and equipment in the patient's home will be adequate for safe and effective care.
   (j) The patient will reside within the geographical area which Heritage Hospice services.
   (k) Any person under the age of 18 must have consent signed by the parent or legal guardian.

2. Referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies and physician offices will assist in the determinate of eligibility for admission to the program. If the request for service is not made by the patient's physician, he/she will be consulted prior to the evaluation visit/initiation of services.

3. During the initial assessment visit, the clinician will re-explain the philosophy, mission and purpose of hospice care and assess the patient's eligibility for hospice services according to the admission criteria to determine/confirm:
   (a) Level of services required;
   (b) Eligibility;
   (c) Source of payment; and
   (d) Service available in defined geographic area.

INITIAL/COMPREHENSIVE ASSESSMENT

Policy No: 2003

PURPOSE

To delineate the process by which patients are evaluated and accepted for service

POLICY

The hospice IDG must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services and the patient's need for physical, psychosocial, emotional, and spiritual care. The comprehensive assessment must include data elements that that allow for measurement of outcomes. This assessments includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions and is updated at least every 15 days.

The Initial Assessment will be completed by the nurse to determine the patient's immediate care and support needs within 48 hours after the hospice receives a physician's admission order for care unless another date is specified by the physician or at the convenience of the patient/family. In the event the initial assessment is delayed the physician will be notified.

The IDG in consultation with the hospice medical director or physician designee and/or the individual's attending physician, complete the comprehensive assessment in a timely manner consistent with the patient's immediate needs, but no later than 5 calendar days after the patient elects the hospice benefit.

Effective	Reviewed	Revised
05-01-2023		

PROCEDURE

1. During the initial visit, the RN will:
   - (a) Explain in a language that they will understand the hospice philosophy, program, Bill of Rights and Responsibilities to the patient/ family/caregiver.
   - (b) Give the patient/family/caregiver information regarding Advance Directives for health care.
   - (c) Assess that the physical facilities and equipment in the home are safe and effective.
   - (d) Allow the patient/family/caregiver a forum for questions which will enable them to make an informed decision regarding hospice services.
   - (e) Review with and have patient/family/caregiver sign appropriate forms once a decision is made to accept hospice services.
   - (f) Complete the initial/comprehensive assessment as pertinent.
   - (g) Determine the patient's immediate care and support needs.
   - (h) Provide services as needed and ordered by the physician and incorporate additional needs into the hospice plan of care.

2. The comprehensive assessment will include at least the following:
   - (a) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).
   - (b) Complications and risk factors that affect care planning.
   - (c) Functional status, including the patient's ability to understand and participate in his or her own care.
   - (d) Imminence of death.
   - (e) Severity of symptoms.
   - (f) Drug profile. A review of all the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:
     - i. Effectiveness of drug therapy.
     - ii. Drug side effects.
     - iii. Actual or potential drug interactions.
     - iv. Duplicate drug therapy.
     - v. Drug therapy currently associated with laboratory monitoring.
   - (g) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment just be incorporated into the plan of care and considered in the bereavement plan of care.
   - (h) The need for referrals and further evaluation by appropriate health professionals.
   - (i) Physical assessment, including vital signs and other relevant data related to the patient's terminal illness.
   - (j) History and progression of illness.
   - (k) An assessment of the severity of pain, including origin, location, duration, severity and current treatment.

- (l) An assessment of the severity of secondary symptoms, such as nausea, vomiting, respiratory status and nutritional status.
- (m) Nutritional assessment.
- (n) Functional assessment.
- (o) DME in the home or needed.
- (p) Identified primary caregiver.
- (q) Spiritual needs.
- (r) Survival risk factors (included in the Social Worker's assessment).
- (s) Volunteer need.
- (t) Alcohol, drug, smoking history.
- (u) TB screening.
- (v) Psychosocial needs.
- (w) Counseling needs.

3. The assessment should determine:
   - (a) Patient/family/caregiver problems, goals, interventions related to terminal illness.
   - (b) Disciplines, frequency and duration of services needed.

4. The nurse will contact the attending physician for clarification/input regarding the plan of care.

5. Assignment of hospice personnel after admission has been verified will be based on the following:
   - (a) The patient's geographical location.
   - (b) Complexity of the patient's care needs.
   - (c) Assigned personnel's level of experience/competence needed to meet that particular patient's care needs (physical, spiritual and psychosocial).

7. All information collected during the initial/comprehensive assessment visit is kept in the patient's clinical record.

8. If the patient proves to be ineligible for hospice care, he/she will be referred to an alternate source for care, when appropriate.

INTAKE PROCESS

Policy No: 2001

PURPOSE

To establish a process for acceptance and handling of intake information for potential patients

POLICY

Heritage Hospice will accept referrals by phone, fax or by written order for potential patients twenty-four hours a day, seven days a week.

Initial contact will be made within 24 hours and documented.

Effective	Reviewed	Revised
05-01-2023		

INTAKE PROCESS
Policy No: 2001

PROCEDURE

1. During scheduled working hours (8:30 a.m. to 5 p.m., Monday through Friday), referrals of patients will be transferred to the Clinical Director/designee.

2. The Clinical Director/designee will obtain/review the following patient information to make the initial determination of whether the patient's needs can be met by Heritage Hospice:
   (a) Demographics;
   (b) Diagnosis (history of, progression, treatment and present status);
   (c) Services needed;
   (d) Medications;
   (e) Attending physician; and
   (f) Hospitalizations, etc. in order.

3. Following an explanation of the philosophy, mission and purpose of hospice, if the patient is deemed appropriate, the attending physician (if not the referring physician) is contacted to confirm service needs, sign a statement of terminality and obtain verbal orders for a physical assessment and admission to Heritage Hospice, if appropriate and qualified.

4. All insurance coverage is verified.
   (a) Managed care is consulted for margins of coverage, special needs and any insurance-specific requirements.

5. If hospice service is deemed inappropriate, the hospice will assist by offering other options and if needed/requested, the appropriate referral will be made.

6. The patient, physician and referral source will be notified if the referral is not accepted based on the intake information.

7. A log will be maintained on all patients that can not be serviced.

8. After scheduled hours (weekends, holidays and evenings) referral sources have access to hospice through the answering service.
   (a) The answering service will contact the nurse on call.
   (b) The on-call nurse will obtain the initial intake information from the referral source.
   (c) The on-call nurse, in consultation with the Clinical Director/designee, will determine whether the patient should be evaluated immediately or is able to be evaluated the next business day.
   (d) If necessary, the on-call nurse will verify eligibility, admit the patient to service, initiate IDT conference for initial care plan and obtain orders.
   (e) If the patient can wait for the next business day, the on-call nurse will provide the Clinical Director with the intake information.

9. Patients will be referred to other resources if Heritage Hospice cannot meet the patient's needs.

SCOPE OF SERVICE
Policy No: 1022

PURPOSE

To describe the services offered by Heritage Hospice.

POLICY

Heritage Hospice provides end-of-life services which are intended to meet the physical, psychosocial and spiritual needs of hospice patients/families/caregivers. A hospice nurse is available to patients/families/ caregivers seven days a week, 24 hours a day. Other disciplines will be available as needed to meet patient/family/caregiver needs.

Effective	Reviewed	Revised
05-01-2023		

PROCEDURE

1. Heritage Hospice will operate an office which will provide a safe and adequate location related to space, facilities and administrative services.

2. Heritage Hospice will be open from 8:30 a.m. to 5:00 p.m., Monday through Friday, except designated holidays and/or other days designated by the Program Director.

3. Nursing services, physician services, and drugs and biologicals (as specified in 418.106) must be made routinely available on a 24-hour basis 7 days a week. Other covered services must be available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family.

4. An administrator from each program office and inpatient unit is scheduled to provide supervisory oversight during on-call.

5. Hospice services will be provided to terminally ill patients in their place of residence. Clinical policies outlining delivery of all hospice services will be followed.

6. An assigned IDT of professionals and volunteers will develop based on hospice's mission, philosophy and purpose with each patient/family/caregiver a plan of care which may include, as appropriate, the following services:
   (a) Physician Services
   (b) Nursing Services
   (c) Medical Social Services
   (d) Therapist, Physical Therapist, Occupational Therapist, Speech Therapist, Respiratory Therapist
   (e) Hospice Aide Services
   (f) Homemaker Services
   (g) Hospice Volunteers Services
   (h) Consultants; Pharmacist
   (i) Durable Medical Equipment (DME)
   (j) Medications and supplies
   (k) Counseling
      i. Spiritual Counseling
      ii. Dietary Counseling
      iii. Bereavement Counseling
   (l) Short term In-Patient Care Services

7. Hospice services will be integrated and coordinated across all settings including hospice care, inpatient and long-term care facilities.

8. Composition of the IDT shall reflect the changing care needs of the patient. At a minimum, the hospice staff shall be composed of:

(a) A hospice administrator/program director who is appointed and works a minimum of halftime for the hospice;
(b) A hospice medical director;
(c) A hospice nurse coordinator;
(d) A hospice social worker;
(e) A pastoral care coordinator; and
(f) A coordinator of volunteer services.

9. The Hospice core serves include:
   (a) Nursing services
   (b) Medical social worker services
   (c) Counseling services
   All core services must be provided by an individual who is an employee or a volunteer of the hospice.

10. Contracting for core services is allowed under limited circumstances:
    (a) Unanticipated periods of high patient loads
    (b) Staffing shortages due to illness or other short-term temporary situations that interrupt patient care
    (c) Temporary travel of a patient outside of the hospices' service area
    (d) Nursing Services: infrequently provided highly specialized services that would be impracticable and prohibitively expensive to provide directly
    (e) May contract with another Medicare certified hospice or another agency

11. As the needs of the patient dictate, and consistent with applicable Federal requirements, the hospice shall provide directly or through contract arrangement the following services: nursing, physician, social work, nutrition, physical therapy, occupational therapy, speech and language pathology, audiology, respiratory therapy, psychological, pharmaceutical, laboratory, medical supplies, equipment and appliances, hospice aide, personal care, housekeeper, homemaker, bereavement, pastoral care and inpatient services.

12. Nursing services in the home shall be provided by or under the direction of hospice personnel who meet the requirements of community health nurse as defined in section 700.2 of this Title or by contractual agreement with a certified home health agency if such arrangement is approved by the commissioner.

13. Physician, nursing, social work, pastoral care and volunteer services shall be provided by the same health care practitioners to the same patient and family, whenever possible.

14. An IDT shall be composed of qualified individuals including, but not limited to, the hospice medical director, hospice nurse coordinator, pastoral care coordinator and hospice social worker who collectively have expertise in assessing the special needs of hospice patients/families, and in providing palliative and supportive care to meet those needs.

15. The IDT provides and supervises hospice care and services.

COORDINATION OF CARE/SERVICES

Policy No: 2009

PURPOSE

To ensure the coordination of care/service provided by the organization and by outside providers

POLICY

Patient care is managed and coordinated in an on-going, consistent manner to assure the highest quality of care.

Effective	Reviewed	Revised
05-01-2023		

COORDINATION OF CARE/SERVICES

Policy No: 2009

PROCEDURE

1. A designated IDG will work together to meet the needs of the hospice patient and families.
2. The organization provides care directly to home-based, nursing home and IPU patients with its own core personnel of medical director, physicians, nurses, social workers and counselors.
3. The organization has agreements to provide general inpatient and respite inpatient services, medications, biologicals, DME and supplies.
4. Hospice home care, nursing home care and inpatient care is delivered by designated, hospice-oriented and trained RNs.
5. Care provided to patients residing in a nursing home follows guidelines as outlined in the organization's nursing home contract or letter of agreement.
6. The hospice program retains responsibility for evaluating services, maintaining professional management responsibility and ensuring continuity of care in all settings.
7. Upon admission of a patient, the IDG will set goals which will include patient/family education. Goals and interventions will be incorporated into the plan of care and updated as necessary.
8. Ensure the on-going sharing of the information between all disciplines (via voicemail, telephone call, etc.) providing care and services in the home, in outpatient settings, and in in-patient setting, irrespective whether the care and services are provided directly or under arrangement. Communication among disciplines should include:
    a. Significant changes in patient's condition or needs.
    b. Patient's primary caregiver unable to continue the support and care the patient requires.

INTERDISCIPLINARY TEAM (IDT) MEETINGS

Policy No: 2011

PURPOSE

To define the process for the IDT meetings and documenting patient status in the clinical record

POLICY

The IDG will meet as needed, but no less than every fifteen days, to discuss patient/family/caregiver updates in the plan of care and comprehensive assessment, as well as deaths and changes in patient/family circumstances.

Effective	Reviewed	Revised
05-01-2023		

PROCEDURE

1. An IDG meeting will be held no less frequently than every fifteen days.

2. The meeting will be facilitated by the Clinical Director/designee.

3. The hospice Medical Director and other IDG members, including RNs, Social Workers, Chaplains or other counselors will be present and may include additional members such as Physical Therapists, Occupational Therapists, Speech/Language Therapists, Dietitians, Pharmacists, HHAs, Homemakers, Volunteers and Attending Physicians, as available.

4. If a member of the IDG can not be present for the team meeting due to illness, vacation/personal time or patient emergency, they must report to a member of their discipline. This report and their input will be given at team and the designated person will represent the absent team member by signing the plan of care.

5. Reviewing new referrals relative to the need for and appropriateness of hospice care.

6. An IDG care plan will be reviewed and modified for each patient/family/caregiver discussed at the team meeting and will note:
   (a) Medication changes.
   (b) Changes in patient clinical status.
   (c) Changes in treatments and/or procedures.
   (d) Changes in frequency of visits and the reason.
   (e) Change in location of care.
   (f) Consultations/conferences with patient/family/caregiver.
   (g) Needs for on-going spiritual and psychosocial support.
   (h) Social, cultural and physical environments that may present obstacles to interventions.
   (i) Special needs of patient.
   (j) Evaluating patient/family/caregiver progress towards achievement of expected outcomes and revising goals and objectives as need it.

7. Discussion of patients who died after the last team meeting and plans for follow-up will be documented on the bereavement plan of care.

8. The signatures of those who attend IDG meetings on the sign in sheet evidence that communication, participation and oversight of patient's care was performed.

9. When more than one IDG operates within the hospice program, the patient will be assigned to the team group responsible for policies governing provision of hospice services at the time of admission by the Clinical Director.

10. Reviewing obstacles to and solution to access for care.

11. Reviewing admissions assuring compliance with hospice policy and procedures.

12. Determining level of services required by the patient and family based on team assessment.

13. Evaluation of current services for effectiveness.

14. Evaluating the appropriateness of re-certification based on identifiable criteria and progression of end stage disease.

15. Planning for transfer based on review of clinical data.

16. Evaluating pharmacotherapeutic effectiveness and symptom management including pharmacodynamics, pharmacokinetics and pharmacotherapies.

17. Integration of alternative therapies to assist with effectiveness of medical regime.

18. Monitoring changes that may contribute to risk for pathological grief.

19. Reviewing discharge of patient and family to ensure appropriateness of care.

20. Assessing grievances and issues of ethical concern.

21. Assistance with transfers and/or relocation of benefit.

22. Confers with a physician or pharmacist to ensure that drugs and biologicals meet each patients needs.

INTERDISCIPLINARY TEAM PLAN OF CARE

Policy No: 2010

PURPOSE

To provide direction to the IDT providing care to the patient and family/ caregiver

POLICY

The IDG in consultation with he patient's attending physician will prepare a written plan of care for each patient. The plan of care will specified the hospice care and services necessary to meet the patient and family specific needs identified in the comprehensive assessment as such needs related to the terminal illness and related conditions. The plan of care will be reviewed at least every 15 days. The patient/family/caregiver will be encouraged to participate in the development of and continued updating of the plan of care.

Effective	Reviewed	Revised
05-01-2023		

PROCEDURE

1. The hospice must develop an individualized written plan of care for each patient prior to the start of care, utilizing information obtained from referral through the nursing admission assessment.

2. The hospice must maintain an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments.
   (a) The plan of care must be signed and dated on the day it is reviewed.
   (b) The attending physician and the medical director or physician designee must review the plan of care for the home care and inpatient care components of service.
   (c) Original frequency of visits will be established and reassessed during every visit and/or as needed.

3. The plan of care will be reviewed and revised as frequently as deemed necessary by the IDG and attending physician based on the updated comprehensive assessment of the patient/family/caregiver needs.
   (a) The plan of care will be updated no less than every 15 days.
   (b) Revision dates will be noted on the plan of care.

4. The patient/family/caregiver and the attending physician will participate in the development of the plan of care and ongoing changes. The patient/family/caregiver will receive education and training as appropriate to the care an services identified in the plan of care. A comprehensive review of the plan of care will be done:
   (a) At the time of significant changes;
   (b) At the end of the hospice certification period; and
   (c) Every 60 days during the unlimited benefit period.

5. The plan of care will be based on the identified problems and contain information of the patient's progress towards desired outcomes and response to care and will include:
   (a) Nursing assessments and plans for interventions and expected outcomes, including client/ caregiver teaching;
   (b) Psychosocial assessments and plan for interventions and expected outcomes;
   (c) Spiritual assessments and plans for interventions and expected outcomes;
   (d) Bereavement assessments and plans for interventions and expected outcomes;
   (e) The IDT assessment and plans for interventions and expected outcomes;
   (f) The medication profile assessment and plans for interventions and expected outcomes. The medication profile will include the patient/family/caregiver ability to safely self-administer drugs and biologicals to the patient in his/her home.
   (g) Designation of a primary caregiver where this is a state requirement; and
   (h) When applicable, plans to meet the special needs of infants, children and adolescents.
   (i) Interventions to facilitate the management of patient an symptoms.
   (j) Detailed statements of the scopes and frequency services necessary to meet the specific patient/family/caregiver need.

(k) Measurable targeted outcomes anticipated from implementing and coordinating the plan of care.
(l) Drugs and treatments necessary to meet the needs of the patient.
(m) Medical supplies and appliances to meet the need of the patient.
(n) Documentation of patient/family/caregiver understanding involvement and agreement with the plan of care.

6. All IDT members, including those providing contracted services, will have access to the plan of care to ensure coordination and continuity.

7. Contract personnel will participate in preparation of the plan of care, submit documentation of services provided including clinical notes, schedule of visits and patient evaluations and participate in IDT meetings.

NURSING SERVICES

Policy No: 2003.1

PURPOSE

To define the role of the nurse in the home

POLICY

The nurse plays a key role in easing physical and psychosocial symptoms and in evaluating and coordinating the needs of the patient.

Effective	Reviewed	Revised
05-01-2023		

PROCEDURE

1. The nurse performs an initial assessment visit within 48 hours after the election of hospice care (unless the physician, patient or representative request that the initial assessment is completed in less than 48 hours), to determine the patient's immediate care and support needs.

2. The nurse in consultation with the attending physician and the IDT will complete a comprehensive assessment no later than 5 calendar days after the patient elects the hospice benefit.

3. The nurse performs on-going assessments of the needs of patients/family/caregivers and identifies risks and interventions and ensures the nursing needs of the patient are met.

4. The nurse develops an initial plan of care with IDT/IDG input.

5. The nurse communicates findings to the attending physician, medical director and IDT/IDG members.

6. The nurse implements the plan of care with a focus on palliative care.

7. The nurse coordinates appropriate referral and follow-up.

8. A nurse oversees care coordination and case management.

9. The nurse conducts on-going evaluation and assessment of the provision of hospice care.

10. The nurse recommends to the IDT/IDG modifications to the plan of care based on patient/family/ caregiver response to hospice services.

11. The nurse facilitates the implementation of another level of hospice care when necessary.

12. The nurse supervises all nursing services in the home:
    a. Hospice Aide
    b. CNAs
    c. Homemakers
    d. LPNs
    e. LVNs

13. The nurse assists with utilization review.

14. The nurse assists with assessment of risks associated with grieving.

15. The nurse documents transportation and arrangements in the clinical record and assumes responsibility for coordination of transportation reports.

16. The nurse communicates between hospice and other health care providers.

17. A nurse is available on a twenty-four hour basis to meet the physical, psychosocial, spiritual and practical needs of patients/families/caregivers, admitted to the program.

18. The nurse reviews and updates Hospice Aide plan of care as patient condition or needs change.

19. The nurse many offer nutritional counseling provided that is within the scope of practice and expertise according to state law.

20. Nurse Practitioners may provide services to beneficiaries receiving hospice care in accordance with state law and within their scope of practice and it must be specified in the plan of care.

SPIRITUAL SERVICES

Policy No: 2003.6

PURPOSE

To provide guidelines for the appropriate assessment and provision of service to meet the spiritual needs of patients and families/caregivers by a qualified professional.

POLICY

Hospice will provide spiritual support/counseling in keeping with the patient/family/caregivers belief system, practice and needs.

Effective	Reviewed	Revised
05-01-2-23		

PROCEDURE

1. A spiritual comprehensive assessment will be done within five days of admission either by phone or, when allowed by the patient/family/caregiver, during the initial spiritual visit

2. If the patient/family/caregiver requests spiritual support or counseling, referral to the appropriate resources will be made, i.e.:
   (a) Their own pastor;
   (b) Community-based clergy;
   (c) A spiritual volunteer; or
   (d) The hospice chaplain.

3. If spiritual services are refused, this will be noted in the clinical record.

4. If intervention is requested or allowed, interventions will be developed as needed and documented on the IDT meeting notes.

BEREAVEMENT SERVICES

Policy No: 2003.7

PURPOSE

To provide guidance for the assessment and re-assessment of the bereavement needs of family/ caregivers by a qualified professional.

POLICY

Heritage Hospice will provide bereavement services/counseling to the surviving family members/caregivers which include but not limited to, residents and staff of SNF/NF/ICF/MF, as needed, for at least 13 months after the patient's death.

Effective	Reviewed	Revised
05-1-2023		

PROCEDURE

1. An initial bereavement risk assessment will be completed by the Social Worker, Bereavement Coordinator or another qualified designee within five days of admission, or at the earliest convenience of the patient/family/caregiver.

2. The bereavement services shall be provided according to the plan of care and reflect the needs of the bereaved.

3. The Bereavement Coordinator may provide supportive counseling to the patient/family/caregiver prior to death.

4. After a death has occurred, the patient is discussed at the next IDT meeting.

5. Within two weeks after the death of a patient a sympathy card will be sent to the bereaved.

6. After three weeks, a bereavement letter is sent to the bereaved giving support and outlining the agency's bereavement services.

7. Within three to five weeks after the patient's death, the bereavement follow-up assessment will be completed by the Bereavement Coordinator following the patient/family/caregiver. This assessment will note and observe the bereaved for symptoms related to grief. The Bereavement Coordinator will render a professional judgment as to whether the bereaved is assessed as needing a routing or high risk follow-up and a bereavement care plan will be initiated.

8. If a person is assessed as routine bereavement, the Bereavement Coordinator will make supportive contact with the bereaved person at the three, six and nine month intervals and at the anniversary of the patient's death. The Bereavement Coordinator will make available to the bereaved person information regarding bereavement support groups, other support groups available in the community and the availability of individual counseling by the hospice personnel.

9. Persons assessed as high risk bereavement will be followed by the bereavement program with increased services and contact offered as noted in the plan of care. Persons identified will be referred to the Bereavement Coordinator and intervention will be provided as follows:
   (a) Bereavement, pastoral care or social work personnel will provide individual counseling to the bereaved.
   (b) A bereavement volunteer who has received additional training in bereavement support may be assigned to make regular contact with those bereaved people and work under the supervision of the bereavement coordinator.
   (c) Referrals to outside professionals may be made, if required.

10. A bereavement file will be maintained on each family/caregiver. Each file will contain the following information:
    (a) Copy of the patient referral and initial bereavement risk assessment;

   (b) Bereavement service checklist;
   (c) All bereavement assessments made;
   (d) A bereavement plan of care; and
   (e) All bereavement clinical notes that have been written and/or sent to the bereaved.

11. On-going bereavement contact is concluded at the end of 13 months if the bereaved is no longer in need of bereavement services.
    (a) A letter will be sent indicating completion of bereavement services and a copy or verification that the letter was sent will be placed in the bereavement file.

12. If, at 13 months, grieving is still perceived as acute, the Bereavement Coordinator will attempt to reassess what additional professional services are necessary and make appropriate referrals if necessary.

13. Bereavement files are to be placed in the patient's permanent clinical record.

ADMISSION GUIDELINES FOR INPATIENT SERVICES

Policy No: 2004.1

PURPOSE

To control acute or chronic symptoms which can not be managed in an alternative setting

POLICY

General inpatient care will be provided as specified under the Medicare or Medicaid and specific private insurance hospice benefits. The IDT will be responsible for identifying and recommending patients who meet general inpatient hospice criteria.

Effective	Reviewed	Revised
05-01-2023		

ADMISSION GUIDELINES FOR INPATIENT SERVICES

Policy No: 2004.1

PROCEDURE

1. One or more of the following clinical criteria must be present in order for the patient to be considered appropriate for admission for general inpatient care. Admission decisions are made on an individual case-by-case basis after evaluation by the hospice IDT and in consultation with the patient's attending physician.
   (a) Pain
      (i) Investigation to define appropriate treatment modality.
      (ii) Active treatment to control pain. May include both change in medications and/or their routes of administration.
      (iii) Titration of medications which can not be done safely at home.
      (iv) Need for advanced technology for analgesic administration (e.g. IV narcotics)
   (b) Other Symptoms
      (i) Death is imminent and care requires on-going and frequent skilled nursing intervention.
      (ii) Symptoms fail to yield to home management. Also, home support has broken down so that it is not feasible to furnish the needed care at home.
      (iii) Severe anorexia and/or inability to swallow necessitating alternative nutritional support and/or routes of administration of medications.
      (iv) Fluctuating/deteriorating mental status necessitating titration of medications, change in environment or consultation and intervention by psychologist or psychiatrist.
      (v) Severe shortness of breath or respiratory distress creating an unmanageable situation for patient/family/caregiver in home care setting.
      (vi) Intractable nausea or vomiting.
      (vii) Open lesions requiring frequent professional care (decubiti, malignant ulcerations, burns, severe abrasions or fistulas – at least b.i.d. dressing changes).
      (viii) Unstable or multiple pathological fractures (requiring great care in moving or transferring patient).
      (ix) Other complicated care: frequent nasotracheal suctioning or GI suctioning, frequent parenteral injections, management of draining fistulas.
      (x) Need for continued close monitoring of unstable recurring medical conditions (e.g. hemorrhage, severe anemia, severe hypertension, unstable diabetes, recurrent severe electrolyte disturbance, recurrent seizures, rapidly re-accumulating ascites or pleural effusion requiring recurrent tapping, recurrent aspiration).
      (xi) Other presenting problems will be identified and evaluated on an individual basis.
   (c) Psychosocial Pathology
      (i) Evaluation of disturbed mental status (e.g. hallucinations, delusions, paranoia, excessive agitation, combativeness) requiring intensive monitoring.
      (ii) Depression, anxiety in the extreme: suicidal ideation, euthanasia, assisted suicide ideation, extreme withdrawal, including inadequate P.O. intake.
      (iii) Failure of support systems manifesting need for evaluation and planning of changed home care management modality.
      (iv) Acutely unsafe home environment: neglect, abuse, inadequate resources to sustain necessities of existence (e.g. food, shelter, including inadequate heat, electricity, etc.)

- (v) Patient's perceptions and/or understandings that respond more positively in a comprehensive care setting that is reassuring, safe and/or therapeutic. Perceptions may include hallucinations, confusion, paranoid ideation and fear about illness/dying.
- (vi) Family/caregiver of the patient is unwilling to permit needed care to be furnished at home.
- (vii) Acute breakdown in family dynamics, preventing family members from functioning as adequate caregivers for reasons that can be physical or emotional.

2. Clinical indications for continued stay in the inpatient unit: one or more of the following clinical criteria must be present in order for the patient to be considered appropriate for continued general inpatient care. Decisions for continued hospitalization are made on an individual case-by-case basis after evaluation by the hospice IDT and in consultation with the patient's attending physician.
   - (a) Pain
     - (i) Active treatment to control pain.
     - (ii) Adjustment of medication levels.
     - (iii) Need for advanced technology for analgesic administration.
     - (iv) Procedures necessary for pain control.
   - (b) Other Symptoms
     - (i) Death is imminent.
     - (ii) Intractable nausea or vomiting.
     - (iii) Respiratory distress.
     - (iv) Open lesions requiring frequent professional care (decubiti, malignant ulceration, burns, severe abrasions or fistulas requiring frequent dressing changes).
     - (v) Unable or multiple pathological fractures (requiring great care in moving or transferring patient).
     - (vi) Complicated care: frequent nasotracheal suctioning or GI suctioning, frequent parenteral injections, management of draining fistulas.
     - (vii) Need for continued close monitoring for unstable recurring medical conditions, (e.g. hemorrhage, severe anemia, severe hypertension, unstable diabetes, recurrent severe electrolyte disturbance, recurrent seizures, rapidly re-accumulating ascites or pleural effusion requiring recurrent tapping or aspiration).
   - (c) Psychosocial Pathology
     - (i) Disturbed mental status (e.g. hallucinations, delusions, paranoia, excessive agitation, combativeness) requiring intensive monitoring.
     - (ii) Depression, anxiety in the extreme: suicidal ideation, euthanasia, assisted suicide ideation, extreme withdrawal, including inadequate oral intake.
     - (iii) Failure of support systems manifesting need for evaluation and planning of changed home care management modality.
     - (iv) Acutely unsafe home environment: neglect, abuse, inadequate resources to sustain necessities of existence (e.g. food, shelter, including adequate heat, electricity, etc.).
     - (v) Patient's perceptions and/or understandings that respond more positively in a comprehensive care setting that is reassuring, safe and/or therapeutic. Perceptions may include hallucinations, confusion, paranoid ideations and fear about illness/dying.

(vi) Family/caregiver of the patient is unwilling to permit needed care to be furnished at home.

(vii) Acute breakdown or disruption in family dynamics, preventing family members from functioning as adequate caregivers, physical or emotional.

ADMISSION FOR RESPITE CARE

Policy No: 2005

PURPOSE

To establish the criteria for admitting a patient for inpatient respite care.

POLICY

Inpatient respite care will be provided by arrangement to patients whose care is covered under the Medicare or Medicaid Hospice Benefit and specific private insurance hospice benefits. Inpatient respite care will be provided at times when the patient/family/caregiver members or family/caregiver(s) need a short period of relief. This is offered on an "as needed" basis for a maximum of five days per respite admission for a Medicare/Medicaid patient. For patients covered by other insurers, the duration may be approved for a longer period of time. Respite care must be provided in a setting other than the home.

The facility providing respite care must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

GENERAL GUIDELINES

Respite care is indicated when:

1. The family/caregiver is unable to continue managing the patient's physical, emotional or psychological needs and requires a break for one to five days.
2. Injury or impairment to the family/caregiver creates a need for respite to provide the family/caregiver and the IDT an opportunity to problem solve.
3. The primary family/caregiver must be out of the home for a period of time greater than 24 hours to attend to urgent affairs, but no longer than five days.
4. Rest or relief is required by the family/caregiver in order to maintain this individual at home.

Effective	**Reviewed**	**Revised**
05-01-2023		

PROCEDURE

1. The hospice primary nurse or social worker will assess the need for respite care and receive approval from the Clinical Director prior to arranging respite.

2. The case manager or designee will obtain orders from the attending physician or designee for respite care.

3. The Clinical Director or social worker will make arrangements with a contract inpatient facility for the patient's admission.

4. The primary nurse or social worker will complete a transfer/change in level of care form and forward to the Clinical Director. The Clinical Director/designee will file a copy in the medical record and forward the original to the respite facility.

5. The primary nurse or social worker will give a verbal report of the patient's condition to the inpatient facility clinical director or designee.

6. The hospice social worker/designee will coordinate with the family to arrange transportation.

7. Hospice personnel will be available 24 hours a day for clinical consultation to the inpatient personnel.

8. The IDT will continue to provide services to the patient/family/caregiver during the period of respite.

9. The IDT will re-evaluate and update the patient plan of care at the time of discharge from respite care.

CONTINUOUS CARE SERVICES

Policy No: 2006

PURPOSE

To establish the criteria and procedures for providing continuous care services to patients

POLICY

Continuous home care will be available to patients on the Medicare or Medicaid hospice benefits, or as other payors allow. Continuous home care, also known as continuous care, can be provided for eight hours or as much as twenty-four hours a day, during periods in which an individual patient/family/ caregiver require continuous nursing care to achieve palliation or to manage acute medical symptoms, in order to maintain the patient at home. The majority of care provided needs to be licensed nursing care, although aide services may also be provided.

Continuous care is not a Heritage Hospice core service. This benefit is covered under Medicare/Medicaid and some private insurance programs.

Effective	Reviewed	Revised
05-01-2023		

PROCEDURE

1. The patient's primary nurse is responsible for assessing if patient requires continuous care.
    (a) The primary nurse confirms this assessment with the Clinical Director/designee.
    (b) During non-business hours, the on-call nurse may initiate continuous care following consultation with the Clinical Director.
    (c) This hospice personnel request and clinical eligibility will be reviewed immediately by the Clinical Director when normal business operations resume.

2. After the primary nurse confirms the need and appropriateness of continuous care with the Clinical Director and/or Program Director, the primary nurse contacts the attending physician.
    (a) The primary nurse will report to the attending physician/medical director the patient's condition, nursing assessment and any other relevant information.
    (b) The primary nurse will document the physician's orders as a verbal order, including the order for continuous care.

3. Continuous care will be provided by qualified personnel under the supervision of the primary nurse. Contracted agencies may be used to supplement the services provided by hospice.

4. The primary nurse, in conjunction with the Clinical Director, will determine the level of skill needed for continuous care. Hospice RNs, LPN/LVNs, contract RNs, LPN/LVNs and/or hospice aides may be utilized to provide this service.
    (a) The patient's predominant need must be for skilled nursing intervention.
    (b) A minimum of eight hours of care must be provided during a 24 hour period which begins and ends at midnight.
    (c) This care need not be continuous, i.e. four hours could be provided in the morning and another four hours provided in the evening of that same day.
    (d) At least fifty percent of this skilled care must be provided by a nurse.

5. For an RN, LPN/LVN, hospice aides or contracted personnel to be eligible to provide continuous care, that person must have a current license/certification to practice in the state. Contract personnel are required to review the continuous care packet and sign the receipt page.

6. The initial report of the patient's condition will be given by the primary nurse or Clinical Director/designee to the nurse or contract person providing continuous care. Shift to shift reporting is the responsibility of the individuals providing continuous care.

7. A continuous care packet will be delivered to the home prior to, or as soon as possible after, continuous care is initiated. The packet will include:
    (a) Continuous care packet receipt page;
    (b) Hospice orientation;
    (c) Continuous care orientation, including:
        (i) Responsibilities
        (ii) Patient management

        (iii) Change in condition
        (iv) Physician orders
        (v) Medication documentation
        (vi) Charting guidelines
        (vii) Contract information
        (viii) Suggestions for improved documentation
    (d) Continuous care interdisciplinary plan of care; and
    (e) Continuous care attendance log.

8. The hospice RN is responsible for initiating the continuous care plan prior to providing service. Any change in the continuous care plan must be approved by the hospice RN to assure continuity of care.

9. Continuous care personnel must notify the hospice RN of any acute changes in the patient status necessitating nursing or medical intervention.

10. The hospice RN will coordinate with the attending physician any changes in medical treatment and the plan of care. The hospice RN will document physician contacts in the patient's clinical record, and the continuous care nurse documents notification of the order.

11. The hospice RN will initiate and oversee the patient's plan of care. A copy of the plan of care is placed in the continuous care packet.

12. Continuous care personnel must be advised that they must work the entire shift which they are assigned and must make an entry into the continuous care log at least every hour, or as instructed.
    (a) If the need to leave earlier arises, they must call the hospice RN or the on-call nurse for approval.
    (b) The continuous care attendance log must be completed.

13. When the decision is made to institute continuous care, the primary nurse and social worker will begin assisting the family/caregiver in planning for care when continuous care is no longer needed or appropriate.

14. The primary nurse or designee will determine, along with the attending physician, when continuous care is no longer needed and notify IDT members to resume routine home care plan of care.

15. The continuous care packet is returned to the Clinical Director.

IMPROVING ORGANIZATIONAL PERFORMANCE

Policy No. 6001

PURPOSE

To establish a performance improvement framework, which integrates activities to improve organizational performance, improve patient outcomes, improve patient safety, and reduce the risks for acquisition and transmission of infections.

POLICY

Senior management as designated by the Governing Body will have the responsibility of quality management: to guide the organization's efforts in improving organizational performance; to define expectations of the performance improvement activities; and to generate the plan and processes the organization will utilize to assess, improve and maintain quality of care and service including the appropriateness and effectiveness of patient services.

Performance improvement results will be utilized to address problem issues, improve the quality of care and patient safety, and will be incorporated into program planning and process design and modifications.

All personnel will be active participants in the organization's performance improvement activities.

The Governing Body is responsible for ensuring that the performance improvement program is defined, implemented and maintained, and is evaluated annually.

PROCEDURE

1. Senior management with Governing Body oversight will:

    A. Participate in educational activities to increase their level of understanding and ability to implement performance improvement activities. The educational activities may include seminars, consultations, periodicals, and review of available information from other organizations (benchmarking).

    B. Set expectations for performance improvement and manage processes to improve organizational performance.

    C. Focus on high risk, high volume, and problem prone areas. There is consideration of incidence, prevalence, and severity of problems in those areas and lead to an immediate correction of any identified problem that directly or potentially threatens the health and safety of the patients.

    D. Adopt a structured framework for performance improvement. The problem solving approach will stress the interrelationship of quality services provided, management activities, and sound business practices as applicable to the organization's:

1. Mission
2. Culture
3. Strategic objectives
4. Resources
5. Operational components/responsibilities (financial, clinical/service, and personnel)
6. Practice Standards
7. Activities related to patient care and patient safety focusing on high risk, high volume and problem prone areas
8. Clinical/service skills and competencies of personnel
9. Quality indicators
10. Data collection and analysis (measured and documented in a systematic and retrievable way)

E. Identify and set specific outcomes for measurable improvement among palliative care and hospice services.

F. Ensure that the performance improvement projects are conducted that reflect the following:

1. The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the organization's services and operations.
2. The organization must document the quality improvement projects undertaken, the reasons for conducting the projects, and the measurable progress achieved on these projects.

G. Ensure that the organization adheres to the CMS Conditions of Participation for Quality Assessment and Performance Improvement (QAPI) standards.

H. Identify and participate in benchmarking activities that utilize:

1. Internal standards:
    a. Measuring current performance against past performance
    b. Measuring against internally established goals
2. Processes and protocols
3. Practice or service guidelines
4. Industry research or best practices

I. Allocate resources for performance improvement activities by:

1. Assigning organization personnel to participate in performance improvement activities

2. Providing adequate time for organization personnel to participate in performance improvement teams and activities

3. Creating and maintaining information systems and data management processes to support the collecting, managing and analyzing of data to improve performance

4. Utilizing appropriate statistical techniques to analyze and display data

    a. Statistical methodologies to consider include:

        i. Run charts that display summary comparison data

        ii. Scatter diagrams

        iii. Control charts that display variation and trends over time

        iv. Histograms

        v. Pareto charts

        vi. Cause and effect or fishbone diagrams

        vii. Process flowcharts

2. Provide organization personnel training in the approaches and methods of assessment and Improvement.

3. All other organization personnel will:

    A. Be involved in performance improvement teams and activities.

    B. Promote communication and coordination of performance improvement activities as well as contribute to those activities.

    C. Forward relevant information regarding performance improvement activities to senior management and to the Performance Improvement Coordinator.

    D. Take action on recommendations generated through performance improvement activities as outlined in the organization's written performance improvement plan.

4. Trends identified through performance improvement measurement and analysis will be reported to the Governing Body on a quarterly basis.

5. Mandatory reporting to CMS will be completed within designated timeframes utilizing CMS reporting guidelines.

ADDENDUM 3-001.A
PRIORITIZATION OF IMPORTANT PROCESSES - EXAMPLE

Process	Required HIS	Regulatory Focus	High Volume	High Risk	Problem-Prone	Expensive to Correct	Impact on Quality	Impact Customer Satisfaction	Variations in Care
General Processes									
Patient Satisfaction									
Safety Program									
Incident Reports									
Documentation									
Infection Control									
Staff Education									
Patient Rights/ Responsibilities									
Ethical Issues									
Use of Information									
Customer Service									
Patient Care Processes									
Intake Process									
Patient Assessment									
Pain Screening									
Pain Assessment									
Pain Management									
Bowel regimen prescribed with opioid order									
Dyspnea Screening									
Dyspnea Treatment									
Medication Administration									
Patient/Family Education									
Treatment Preferences									
Care Coordination									
Nursing Process									
MSW - Counseling									

Affinity Care

Process	Required HIS	Regulatory Focus	High Volume	High Risk	Problem-Prone	Expensive to Correct	Impact on Quality	Impact Customer Satisfaction	Variations in Care
MSW - Psychosocial Assessment									
Volunteers									
Spiritual Care									
Beliefs/Values Addressed									
Terminal Care									
Wound/Skin Care Management									
Foley/Urological Care									
Neurological Care									
Respiratory Care									
Cert/Recert Process									
Discharge Process									
Bereavement									
Personal Care									
Personal Care Plan									
CNA/Hospice Aide Communication									
Governance/Managerial									
Analysis of Effectiveness of Organizational Practices									
Development of Operational Plans									
Compliance with Regulatory Mandates									
Assigning/Acquiring Resources to Foster Quality									
Fostering Interdisciplinary Communication									
Assignment of Staff Responsibilities									

Heritage Hospice

Process	Required HIS	Regulatory Focus	High Volume	High Risk	Problem-Prone	Expensive to Correct	Impact on Quality	Impact Customer Satisfaction	Variations in Care
Management of Information									
Safety Plan Effectiveness									
Clerical									
Telephone Technique									
Coordination of Mail Between Offices									
Ordering of Supplies									
Ordering of Forms									
Tracking of Physician Orders									
Human Resources									
General Orientation/Competency Assessment									
Processing of Worker's Compensation Claims									
Handling of Employee Grievances									
Recruitment									
Personnel Policy Development									
Financial Support									
Cost Analysis Reports									
Payroll									
Accounts Receivable Management									
Data Entry									
Charge Entry									
Generation of POC/Recert									
Discipline Visit Entry									
Insurance Verifications									
Other Organization-Specific Processes									

Affinity Care

Process	Required HIS	Regulatory Focus	High Volume	High Risk	Problem-Prone	Expensive to Correct	Impact on Quality	Impact Customer Satisfaction	Variations in Care
Totals									

Scoring Values 1 = Least Significant 2 = Mildly Significant 3 = Strongly Significant

GENERAL CRITERIA FOR CERTIFICATE OF NEED

NEED

ITEM 1N: Service Specific Standards and Criteria - Hospice

The following apply:

1. **Adequate Staffing:** An applicant should document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application. Importantly, the applicant must document that such qualified personnel are available for hire to work in the proposed service area. In this regard, an applicant should demonstrate its willingness to comply with the general staffing guidelines and qualifications set forth by the National Hospice and Palliative Care Organization.

   Rationale: Health care professionals, including those who provide hospice services, are not uniformly located across the state, and rural areas showing some need for hospice services may not have a qualified hospice workforce. The Division believes that granting a CON for the provision of health care services without evidence that the applicant has a qualified workforce readily available to provide quality care to patients is not, in fact, providing access to quality health care.

RESPONSE:

Given the diversity of the Service Area which includes the Chattanooga MSA (Hamilton, Sequatchie and Marion Counties), Cleveland MSA (Bradley and Polk Counties) and five surrounding rural counties, Heritage Hospice will vary its recruitment techniques. The majority of the patients, based on total population and black population dispersion, are expected to reside in Hamilton and Bradley Counties. Therefore, it is expected that the majority of the recruitment will occur in these two counties.

Between Bradley and Hamilton Counties, there are in excess of 8,500 registered nurses as shown in the following RN inventory compiled by the State of Tennessee.

Heritage Hospice Service Area
Registered Nursing Inventory, 2021 through 2023

County	2021	2022	2023	2-Year Change
Bledsoe	121	120	126	4.1%
Bradley	1,501	1,567	1,573	4.8%
Hamilton	6,843	6,941	6,981	2.0%
McMinn	562	575	582	3.6%
Meigs	119	124	130	9.2%
Monroe	428	433	435	1.6%
Polk	209	218	221	5.7%
Rhea	268	281	287	7.1%
Sequatchie	182	185	190	4.4%
Service Area	**10,603**	**10,833**	**10,912**	**2.9%**

Source: https://tnmap.tn.gov/health/nursing

Leadership understands how to recruit the staff necessary to adequately provide the services to the expected patient population. Heritage Hospice has also budgeted sufficient remote technology in its project cost to be sure each direct patient care worker has electronic means to communicate with the electronic medical record, the interdisciplinary team (IDT), quality and leadership to ensure the provision of quality care. Given this technology, it is also possible to recruit individuals who live in the rural counties within the Service Area as personally accessing the home office is not necessary.

In terms of staffing and staffing levels, Heritage Hospice is committed to exceeding the general staffing guidelines set forth by the National Hospice and Palliative Care Organization (NHPCO). The NHPCO guidelines are designed to enable each hospice provider to estimate optimal staffing caseloads depending on their particular situation. Hospice care is diverse and the models for staffing are driven by variations in patient populations, population density, travel time, and other factors. The staffing guidelines outline a process for a hospice agency to analyze the different factors to help it determine the staffing ratios that are best for its hospice. The NHPCO staffing guidelines outline the process so each hospice agency can determine an appropriate number of staff based on its particular location, type of patients served, and other factors.

It is Heritage Hospice's position that given the underserved nature of the Service Area's Black population, it is necessary to provide a staff intensity that exceeds the NHPCO guidelines to assure there are more patient touches on a regular basis for the patients to be served. This operating model will enable Heritage Hospice to provide additional comfort to the underserved patient and their family through the development of a trusting relationship. The staff will also be thoroughly trained in the background, issues and concerns that the racial disparity studies previously identified to have the staff assist in quelling any fears, obstacles or other barriers to enable a positive end of life journey.

Heritage Hospice will use a variety of recruiting techniques to secure highly qualified talent. These methodologies include local advertising such as social media and job fairs, and recruitment from local technical colleges and universities. Leadership also has well established relationships throughout Georgia, Alabama and southeast Tennessee to assist in recruitment efforts.

As a nurse, Ms. Hamilton understands nursing education is the bedrock for growing the population of skilled nurses. There are at least 12 professional nursing schools within and around the service area that Heritage Hospice will seek to establish relations with to provide training in the provision of end of life care to the region's future nurses. The schools identified include the following:

Professional Nursing School	Location
Chattanooga College Medical Dental and Technical Careers Nursing School	Chattanooga, TN
Chattanooga State Community College Nursing School	Chattanooga, TN
Cleveland State Community College Nursing School	Cleveland, TN
Lee University Nursing School	Cleveland, TN
Platt College-Miller-Motte Technical-Chattanooga Nursing School	Chattanooga, TN
Roane State Community College Nursing School	Harriman, TN
Southern Adventist University Nursing School	Collegedale, TN
Tennessee College of Applied Technology-Athens of Nursing	Athens, TN
Tennessee College of Applied Technology-McMinnville of Nursing	Minnville, TN
Tennessee Wesleyan University Nursing School	Athens, TN
The University of Tennessee-Chattanooga Nursing School	Chattanooga, TN

A key element in the delivery of quality patient care is the quality of its staff. Heritage Hospice will place heavy emphasis on recruiting and maintaining high-quality professional staff. Effectiveness in meeting this goal results from a combination of competitive wages and employee benefits, education and training and performance evaluation. Staff training is integral to the delivery of quality care. All personnel will actively participate in the staff training programs and will be specifically trained on overcoming racial disparities in the provision of end of life hospice care.

Collectively with the above strategies, the Applicant does not foresee any difficulties in attracting and retaining qualified employees.

2. **Community Linkage Plan:** The applicant should provide a community linkage plan that demonstrates factors such as, but not limited to, relationships with appropriate health caresystem providers/services and working agreements with other related community servicesassuring continuity of care focusing on coordinated, integrated systems. Letters from physicians in support of an application should detail specific instances of unmet need for hospice services.

RESPONSE:

The Applicant has already begun meeting with healthcare providers in the Service Area including representatives of health systems, nursing home and assisted living facility administrators, community organizations, ministries and physicians. As of this early date, the Applicant has garnered support in terms of a letter from the following Service Area constituents:

- Erlanger Health System, Angel Moore, CEO, Erlanger Health Centers
- Urban League of Greater Chattanooga Area, Greg Funderburg, Marketing Director
- Nivaq Ministries International, Gavin Lynn Steward
- Smith Bone Consulting Group, Vickye Bone, Former VP Urban League of Greater Chattanooga
- The Waters of Sweetwater Rehab and Nursing Center, Monroe County SNF
- Decatur Wellness and Rehabilitation Center, Meigs County SNF
- Soddy Daisy Healthcare Center, Hamilton County SNF
- Morningside of Cleveland, Bradley County ALF
- The Lanterns Alzheimer's Center, Hamilton County ALF
- Brookdale Mount Vernon Drive, Bradley County ALF
- Dominion of Hixson, Hamilton County ALF
- Garden Plaza at Cleveland, Bradley County ALF
- American House Shallowford, Hamilton County ALF (2 letters)
- American House Hamilton Place, Hamilton County ALF
- Dr. Andrew Alward, NewTread Podiatry, Hamilton County
- Dr. Christopher Prater, Hamilton County
- Dr. Anthony G. Avitabile, Hamilton County

The letters of support from the above constituents are supplied in **Attachment 1N-2.** Excerpts from some of those letters are provided as follows.

Angel Moore, CEO, Erlanger Health Centers, Erlanger Health System

> *"…As a community safety net leader am involved first-hand in our delivery of healthcare and witness firsthand that many of our patients require education of various aspects of the healthcare system, continuum of healthcare services, and services which are funded through Medicaid and Medicare. We do our best to direct our patients to seek and receive quality healthcare in all phases of their life. Notwithstanding our efforts, we regularly observe that our patients go without end of life home hospice care due to lack of knowledge, resources or understanding. The existing end of life programs in our market have very low numbers for this population of which the goal is to dispel with the disparities in access to such care by minorities.*

> *Our safety net would value a new hospice provider that has a commitment and mission to raise hospice awareness and enrollment for this population throughout our service areas. Having engaged with Heritage Hospice, we believe Heritage Hospice will be that provider. I will work with Heritage to educate, counsel and ultimately enhance hospice utilization amongst this minority population in southeast Tennessee, including our patients.*
>
> *The disparity of hospice utilization is significant and can only be addressed through CON approval of Heritage Hospice. Please approve Heritage Hospice to provide hospice services in southeast Tennessee so that we may work together to enhance end of life care thereby improving quality for the minorities in our service area. Thank you in advance for your consideration and approval..."*

Vickye Bone, Smith Bone Consulting, Former VP Urban League of Greater Chattanooga

> *"…I firmly believe that Heritage Hospice is on the road to great success in Tennessee. They have a service that is greatly needed in the community, and leadership with extensive experience in this sensitive area of healthcare. When reviewing businesses, my first concern is whether leadership has a plan and strategy that will lead them to success. With Heritage Hospice I give a resounding "yes" when responding to this question, as the leadership team has demonstrated an excellent understanding of how their services will fit into the Chattanooga market. They are also prepared to do the "feet on the ground" work necessary to truly engage the community.*
>
> *Though healthcare has improved significantly for all Americans, one constant is that life expectancy for African Americans lags that of Whites. The African American community has less access to appropriate health care, including preventative care, and that leads to higher incidences of obesity, cancer, and other chronic illnesses that become fatal. People of color often receive a disease diagnosis at late stages with worse outcomes. Therefore, African Americans are not only more susceptible to disease and illness, they are also more likely to die from them.*
>
> *Johns Hopkins Medicine researchers published a report which indicates that African American patients seek more medically intensive treatment and multiple emergency room visits in the last six months of life, while White patients more often choose hospice services. The researchers found that 34.9% of African Americans who died used hospice services over the study period, compared with 46.2% of Whites. Spiritual beliefs, cultural systems, and mistrust of the medical system help explain Black patients' preferences for life-sustaining treatments. There is also less engagement in planning end-of-life strategies and thus less use of hospice and palliative care. Inadequate physician communication can also cause patients to misunderstand, and thus fail to utilize, hospice services.*
>
> *With this information as a backdrop, I had the opportunity to meet with Tywanna Hamilton, President of Heritage Hospice, who has developed an in-home hospice program to meet the end of life care needs for the terminally ill African-American population. Knowing our community, I am able to state first hand that the Chattanooga African-American population is disadvantaged when it comes to accessing hospice services. They aren't aware of its benefits, when to access such a program and may even be skeptical to seek services for their passing. Knowing that a hospice program is covered by Medicare and Medicaid would also be important to our constituents as the benefit not only covers the care but also supplies, pharmacy and other necessities. Heritage Hospice has shared with me their plan to lift up the*

African-American population in our area by enhancing access to hospice services through education, relationship building and high quality services in the person's home.

I support the Heritage Hospice approach to delivering services. The Tennessee Health Facilities Commission approval of the Heritage Hospice certificate of need application to establish a hospice in southeast Tennessee that addresses the underserved needs of our area's African-American population is critical. Once approved, I firmly believe that the African American community will support Heritage Hospice as a superior provider of hospice and palliative care…"

Greg Funderburg, Marketing Director, Urban League of Greater Chattanooga

"I am a member of the National Association of Black Journalists and Kappa Alpha Psi Fraternity, Inc. Aside from my civic work, I enjoy speaking to youth about the importance of education, hard work, determination and dedication. I make it my number one priority to give back to my local community.

I have had the opportunity to meet with Tywanna Hamilton of Heritage Hospice. In my short time of meeting with her, I know my community, as a whole would benefit from having a hospice that's focused on educating the community about hospice to bridge the gap for our minority population in accessing the much needed end-of-life care through hospice.

Allowing Heritage Hospice to establish a hospice in our community which will educate the African American population on these programs, enhance access and provide meaningful end of life care is important to us collectively…."

Gavin Lynn Steward, CEO/Director, Nivaq Ministries International and Board Member Pneuma Christian Center

"…In my meeting with Heritage Hospice leadership, I knew I was hearing many shared passions and that my community would benefit from having a hospice focused on our elderly minority population and educating the community about hospice. The end-of-life care is so important to elderly minority population. Allowing Heritage Hospice to establish a hospice in our community which will educate the elderly black population on these programs, enhance access and provide meaningful end of life care is important to my community…."

Ray Allen, RN, LNHA, Administrator, Soddy Daisy Healthcare Center

"…The diversity of Hamilton County is well known, with approximately 18 percent of the population being black and an additional 6 percent being Hispanic. With our experience, we have observed that the minority population accesses important end of life hospice care at a lower rate than the rest of the population. This happens within our community and we understand it occurs elsewhere as well.

Heritage Hospice is seeking certificate of need approval to establish a hospice to specialize in reaching the black population and enhancing their appropriate use of hospice care. We believe this is an important element that is much needed in Hamilton County. The black population has been disadvantaged with healthcare access and Heritage Hospice is focused on providing services to this underserved population group.

> *Given Heritage Hospice's programming, I am strongly advocating for the Tennessee Health Facilities Commission to approve the Heritage Hospice CON application to provide hospice services for the black population and other persons in our region of the state…."*

Managing Member, Decatur Wellness and Rehabilitation Center, Meigs County

> *"…we believe that on occasion area residents may have hampered access to end of life hospice services. I have had the opportunity to learn about Heritage Hospice. It is my understanding they have conducted specific research of this region and determined it to be underserved relative to end-of-life care which is consistent with our observations regarding hospice care in general and hospice for minorities. My understanding about Heritage Hospice and how it will make a difference in our service area includes the following:*
>
> - *Be Medicaid certified to accept any Medicaid clients*
> - *Admit any qualifying hospice patient even if a charity care patient*
>
> *Admit patients during both day and night, including weekends to enable family participation after work or days off*
>
> - *Educating our professional staff on palliative and hospice care resources and how to incorporate into our treatment plans when appropriate*
> - *Assist our facility in educating the community regarding end of life care*
> - *Providing spiritual support for patients and families*

Kristie Valentino, BSW, Administrator, The Waters of Sweetwater Rehab and Nursing Center, Monroe County

> *"..I understand that Heritage Hospice is submitting a Certificate of Need application to eliminate the racial disparities which are evident in our region with respect to hospice services. I believe Heritage Hospice will add tremendous value to the residents of our service area and should be awarded the CON. The services this company will provide are focused on minorities and not what the local hospice programs provide. And given the unserved need of the black and minority population in our region, it is incumbent on the Health Facilities Commission to authorize Heritage Hospice to provide hospice services in our region.*

Pam Turley, RN, Administrator, Morningside of Cleveland, Bradley County

> *"..I met with Heritage Hospice representatives and believe they have the ability to lift up the minority hospice penetration in southeast Tennessee. This will add tremendous value to the residents of our service area as existing providers have been unable to minimize the disparity in hospice utilization amongst differing races. Unlike the existing providers, Heritage Hospice has a culturally competent strategy to address disparities in minority populations, particularly with respect to the Black and Hispanic populations… Heritage Hospice, if approved, will augment hospice utilization for these minority groups through education on end of life care, comprehensive outreach and specifically tailored programs to enhance minority hospice utilization. … I would also anticipate them working with our medical director and case managers in assessing our residents likely resulting in a couple of referrals per month…"*

Larry Griffin, Executive Director, The Lantern at Morning Pointe, Hamilton County

> *"…The diversity of Hamilton County is well known, with approximately 17 percent of the population being black and an additional 8 percent being Hispanic. We understand the lack of access to hospice care in our community and believe this to be the same in other surrounding communities. I had the opportunity to meet with Heritage Hospice to review their*

> *strategy to meet the needs for the terminally ill minority population, I believe there is a lack of awareness of hospice services which puts them at risk of dying without end-life care. In reviewing Heritage Hospice's plan it will decrease the lack of hospice education services through their quality education outreach. …"*

Wendy Owens, Executive Director, Brookdale Mount Vernon Drive, Bradley County

> *"…I had the pleasure of meeting with Tywanna Hamilton, President of Heritage Hospice and learned about their efforts to increase hospice accessibility within the minority population if their Certificate of Need Application is approved. I understand that Heritage Hospice is seeking to provide hospice services in our community which will definitely benefit from an additional hospice provider. In addition to working to reach the minority population their increased service intensity is impressive, and Heritage Hospice has a focused program to enroll patients in hospice care, targeting a reduction in the gap of services and enhancing access to hospice. …"*

Cody Workman, Executive Director, Dominion of Hixon, Hamilton County

> *"…Heritage Hospice has shared with me their plan to increase the African- American and Latino population in our area by enhancing access to hospice services through education, relationship building and high quality services in the person's home. To enhance the quality of services and bridge the gap in hospice accessibility in our community, please approve Heritage Hospice's proposal to establish a new hospice …"*

Brittany Sinclair, Resident Care Director, Garden Plaza at Cleveland, Bradley County

> *"…Our County will definitely benefit from an additional hospice provider. … Unlike the existing providers, Heritage Hospice has a culturally competent strategy to address disparities in minority populations, … if approved, will augment hospice utilization for these minority groups… I expect to work with Heritage Hospice in our community enabling them to educate our residents, families and others. ... likely resulting in a couple of referrals per month…"*

Lawrence Brewer, Community Relations Director, American House Shallowford, Hamilton County

> *"…I have reviewed the information on Heritage Hospice's cultural programs and increased service intensity and am a strong advocate for this service. I look forward to American House Shallowford Place contracting with Heritage Hospice to increase hospice accessibility within our community. Heritage Hospice has shared with me their plan to increase the African-American and Latino population in our area by enhancing access to hospice services through education, relationship building and high quality services in the person's home. We will support their efforts by referring 2-3 appropriate residents per month. To enhance the quality of services and bridge the gap in hospice accessibility in our community, please approve Heritage Hospice's proposal to establish a new hospice program. …"*

Andrew Alward, DPM, FACPM, NewTread Podiatry, Hamilton County

> *"…I feel confident Heritage Hospice has an appropriate business plan to mitigate the racial disparities in hospice care in our region. Allowing Heritage Hospice to establish a hospice in our community which will educate the black population on these programs, enhance access and provide meaningful end of life care is important to me personally, and to our community.*

> *Given the minority population in our area is underserved, I wholeheartedly support the approval of Heritage Hospice to establish a hospice in this region. We look forward to working with Heritage Hospice upon their licensure. …"*

Christopher Prater, MD, Hamilton County

> *"…I had the pleasure of meeting with Tywanna Hamilton, representative of Heritage Hospice, regarding Heritage Hospice's plan to establishing an end-of-life hospice program with a focus on the underserved population. With a near 17 percent black population in Hamilton County, that is admirable. It is my belief Heritage Hospice has the knowledge and ability to increase the awareness and access to hospice care within the minority population. Heritage Hospice has shared with me their plan to lift up the underserved population in our area by enhancing access to hospice services through education, relationship building and high quality services in the person's home. Given their vision, I am in strong support for their Certificate of Need Application Approval to establish an additional hospice program in our community. Once approved, I expect I would refer one to two patients per month to Heritage Hospice. …"*

Anthony Avitabile, DO, FAAFP, RiverCity Family Medicine, PLLC, Hamilton County

> *"…I was made aware of their plan for establishing an end-of-life hospice program with a focus on the underserved population. It is my belief Heritage Hospice has the knowledge and ability to increase the awareness and access to hospice care within the minority population. Heritage Hospice has shared with me their plan to lift up the underserved population in our area by enhancing access to hospice services through education, relationship building and high quality services in the person's home. Understanding their proposed efforts. I am in strong support for their Certificate of Need Application Approval to establish an additional hospice program in our community. …"*

The Applicant's Community Linkage Plan described below demonstrates that it has begun to formulate relationships with service area hospitals, nursing homes, assisted living facilities and others to ensure that, once operational in the Service Area, Heritage Hospice will provide coordinated care for end of life patients with its particular focus on the underserved Black population in need of end of life care. This plan is consistent with the original 2006 edition of The African-American Spiritual and Ethical Guide to End of Life Care which has just released its 9th edition including advanced directives.[1] The purpose of the Guide provides a framework for some of Heritage Hospice's initiatives which are incorporated into its Community Linkage Plan. A copy of the Guide is included in **Attachment 4N**, along with other articles and documents referencing the underserved Black population.

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[1] Dr. Gloria Thomas Anderson, a university-level assistant professor and licensed social worker, wrote the first edition of The African-American Spiritual and Ethical Guide to End-of-Life Care in 2006 after receiving a grant to produce her research findings into a patient education resource to offer relevant information about end of life care specifically for African Americans.

Community Linkage Plan

Objective of Proposed Plan*:* To lift up the hospice penetration rate for Black population to minimize and/or eliminate racial disparities in end of life hospice care.

Strategies to Accomplish the Objective: Network with existing healthcare providers and referral sources throughout the Service area. Work with the Urban League of Greater Chattanooga to sponsor educational programs for the Black population and particularly the Black senior population. Educate the existing healthcare providers and referral sources about the unique attributes of Heritage Hospice and the terminally ill population it will serve. Be included on each of the existing healthcare providers and referral sources provider list distributed to their patient population. Establish formal referral relationships with physicians who manage the care of hospice appropriate patients. Create opportunities to integrate Heritage Hospice clinicians within the professional community to provide education and support for social service organizations active in the community. Develop marketing materials and brochures detailing the unique patient focus of the Heritage Hospice and distribute these materials throughout the Service Area including at the Erlanger Health Centers. Work collaboratively with other organizations providing like services to appropriately integrate Heritage Hospice within the post-acute continuum of care. Counsel families, patients and others on service availability and resources within the community to achieve continuity of service. Address the unique cultural, historical and spiritual values in the decision-making process. Overcome historical barriers of mistrust, miscommunication, and cultural competency concerns all of which result in racial disparities. Employ active members of the Black community to ensure it remains engrained and attuned to the entire end of life needs of this demographic to ameliorate the misconceptions of hospice care and ensure each resident has equal access to the hospice benefit. Cultivate a set of tools and practices to address the cultural, health systems and other impediments to hospice care that confront the underserved population. Develop a culturally sensitive intervention to increase awareness and understanding of advanced care planning, palliative care and hospice among members of the Black community.

Networking with Existing Healthcare Providers and Referral Sources, Educating these Sources, and Developing Referral Relationships*:* Heritage Hospice will contact each organization that provided a letter of support, and all hospitals, nursing homes and assisted living facilities in the Service Area to introduce its organization and the programs and services it offers. Heritage Hospice representatives will present to each audience and provider, its unique capabilities, services, and its purpose of lifting up the hospice penetration rate for Black population to minimize and/or eliminate racial disparities in end of life hospice care.

This includes Erlanger Health System and its Erlanger Health Centers, a safety net provider throughout the Service Area. Given this system's support of Heritage Hospice, it expects a strong collaborative relationship to identify and meet the needs of the underserved Black population.

After the initial contact with these providers, Heritage Hospice will maintain ongoing regular communication to facilitate referrals and obtain feedback from these providers on their satisfaction with the Heritage Hospice services and team members. It will also include these providers in its educational services to educate their professionals and their patients/families in end of life care benefits, resources and community support available to meet their needs. It will also offer bereavement support ongoingly to these providers' professionals, patients and families.

Establishing Formal Referral Relationships with Physicians: Heritage Hospice will contact the physicians who care for patients in the Service Area including but not limited to internist, family practitioners, geriatricians, cardiologists, nephrologists, endocrinologists, pulmonologists, and hematologists. The initial group of physicians have been identified for networking and responding to their patients' end of life needs. One quantified monthly referrals at one to two per month in his letter of support. Its physician database will be updated on a regular basis to assure it is current and the community networking with physicians is comprehensive. Heritage Hospice will maintain regular communication with these physicians to assure their and their patients' expectations are met, any feedback on services and any opportunities to enhance services as part of the Community Linkage Plan.

Creating Opportunities to Integrate Heritage Hospice Staff and Clinicians within the Professional Community to Provide Education and Support for Social Service Organizations Active in the Community: Heritage Hospice will work with the Urban League of Greater Chattanooga, Naviq Ministries International, and other organizations and ministries to enhance access to hospice eligible populations. It will offer educational seminars on a regular basis, provide educational materials to these parties and attendees and regularly communicate with its constituents. It will also coordinate and provide referral to necessary social, economic and health services for patients and their families who need social and welfare services. By working with these organizations, the Applicant will provide its patients and families with information and referral to appropriately placed social service organizations to the benefit of the community at large.

The Applicant will maintain regular communication with these organizations, ministries and others to be identified to assure it is an effective member of the community, with a comprehensive Community Linkage Plan. The Applicant will document the service linkage in the Heritage Hospice patient record and maintain periodic follow up with the referral organization. The Applicant will evaluate the effectiveness of the services, the patient/family satisfaction of the services and the coordination and communication of the services provided. The Applicant will report its findings relative to the services provided and incorporate these findings into their regular QAPI meetings.

Establishing a Palliative Care Program to Educate the Community on Pre-Hospice Services, Using Palliative Care as a Bridge to End of Life Care, Counsel on Service Availability and Resources to Achieve Continuity of Service: The Applicant will provide education regarding end of life and other services directly to potential patients in both Hamilton and Bradley Counties, and its surrounding rural counties. They will regularly attend and coordinate community outreach events. Furthermore, Heritage Hospice will establish a palliative care affiliate to identify palliative care patients who are more appropriate for hospice care. This affiliate will be established by the second year of operation of Heritage Hospice in this Service Area. Palliative care, unlike hospice care, regularly entails the provision of curative treatment to patients but is often provided in a hospital setting as opposed to the patient's home. In many instances, after a palliative care clinician has established an ongoing relationship with a patient who is eligible for hospice, they have the ability to spend more one-on-one time with the patient to discuss the specific disease process, where that particular patient is in the process, and potential options moving forward. These conversations are aimed to give the patient and their family a more defined understanding regarding potential outcomes and provide perspective on what each care path entails. This counseling will also address other resources available in the community that will benefit the patient and their family.

Employing Active Members of the Black Community, Cultivating a Set of Tools and Practices to Address the Cultural, Health System and Other Impediments to Hospice Care, and Develop a Culturally Sensitive Intervention to Increase Awareness and Understanding of Advanced Care Planning, Palliative Care and Hospice Among Members of the Black Community : Operationally, Heritage Hospice will develop a set of tools and practices to address the cultural, health systems and other impediments to hospice care that confront the underserved population. It will also seek to increase awareness and understanding of advanced care planning, palliative care and hospice through culturally sensitive interventions. Heritage Hospice will formulate mechanisms that focus on building trust in the Black cohort and partner with existing community resources that service the Black community such as Urban League, churches and community centers. Heritage Hospice will employ active members of the local Black community to ensure it remains engrained and attuned to the entire end of life needs of this demographic to ameliorate the misconceptions of hospice care and ensure each resident has equal access to the hospice benefit. Heritage Hospice will also carry out an array of regularly scheduled community education events and take every opportunity to educate those who may have a deep-rooted mistrust of healthcare, and of hospice.

The Applicant's Community Linkage Plan will be regularly updated after licensure to ensure the Applicant is an active and integral provider in the Service Area to enhance access to and availability of services for the identified underserved Black Service Area population.

3. **Proposed Charges:** The applicant should list its benefit level charges, which should be reasonable in comparison with those of other similar facilities in the service area or in adjoining service areas.

RESPONSE:

The charge structure for hospice services is typically established from Medicare reimbursement formulas based on the designated level of service. Accordingly, most hospices utilize the same pricing and there are not distinguishable differences amongst providers. Proposed charges utilized in the Projected Data Chart are based on Medicare reimbursement and are therefore reasonable in comparison with charges of other hospice agencies in the service area, and the remainder of Tennessee. The Applicant anticipates a net charge of $173 per patient day for the first year of operation and $180 per patient day in the second year of operation.

Demonstrated below, the Applicant's year two charges compare favorably to those of other service area providers.

Rates by Hospice Agency within the Service Area Counties
Fiscal Year 2022

State ID	Hospice Agency	Routine	Continous	Inpatient	Respite
05602	Blount Memorial Hospital Hospice	$172	$1,236	$912	$411
06063 & 06613	Adoration Home Health & Hospice Care East TN	$177	$1,248	$933	$416
06603	Kindred Hospice	$177	$1,243	$933	$416
19694	Avalon Hospice	$186	$1,322	$982	$437
33603	Amedisys Hospice an Adventa Company	$149	$500	$886	$417
33643	Avalon Hospice	$183	$1,303	$970	$432
33653	Caris Healthcare	$184	$1,303	$970	$432
33673	Hearth Hospice of Tennessee	$192	$1,380	$1,010	$447
33613	Hospice of Chattanooga Inc	$177	$1,396	$936	$420
47602	Amedisys Hospice an Adventa Company	$146	$500	$911	$403
47682	Caris Healthcare	$177	$1,243	$933	$416
47402 & 47632	Covenant Homecare	$177	$1,242	$933	$416
47132 & 47662	UTMCK-Home Care Services: Hospice & Home Care	$153	$1,236	$1,077	$402
71604	Kindred Hospice	$177	$1,243	$933	$416
Average, Licensed Hospice Agency, FY2022		**$162**	**$1,093**	**$888**	**$392**
Average, Licensed Hospice Agency in Service Area, FY2022		**$177**	**$1,196**	**$948**	**$426**

Source: Joint Annual Reports by Provider, Page 6, FY 2022 with exception of Blount Memorial, Hearth Hospice and Hospice of Chattanooga; these latter three are 2021 as 2022 is not available. The highlighted providers are those based in the Service Area.

The charges above are based on Medicare established rates as reported in each hospice's Joint Annual Report. These rates are established by Medicare and fairly consistently used universally by all payor types. Differences in routine rates among providers are (1) based on the geography of the patient's residence; and (2) the mix of patient days in the 1-60 or 60+ day category. Medicare reimbursement decreases after the 60th day. While mix of patients in the routine categories is not evident from the information, those hospices based in the Service Area counties (highlighted in yellow) have higher average routine charges per day than the average of the 14 licensed providers. Additionally, continuous care is paid on an hourly basis. The $1,093 to $1,196 rate is derived from a 24-hour encounter; the lower rate is likely and 8 to 10 hour experience by that particular provider.

Based on the above charges, and Medicare rates as published by CMS adjusted for geography, Heritage Hospice's Year 2 (2025) is on par with the Service Area provider's average net revenue per patient day. Specifically, in 2022 the routine rate of $162 overall, or $177 for the Service Area hospices, inflated by three years to the forecasted time frame, results in $177 to $193 per day for routine days. Heritage Hospice's year two forecast of $180 is reasonable and takes into account 98 percent routine, 1 percent respite and 1 percent inpatient. In addition to reasonable charges, the Applicant will treat any hospice eligible patient in the Service Area seeking admission to Heritage Hospice without regard to the person's ability to pay.

4. **Access:** The applicant must demonstrate an ability and willingness to serve equally all of the Service Area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing the factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed service area.

RESPONSE:

Heritage Hospice is seeking Certificate of Need approval to establish a new in-home hospice agency that will address racial disparities in the Black population in southeast Tennessee. The Service Area includes Bledsoe, Bradley, Hamilton, Marion, McMinn, Meigs, Monroe, Polk, Rhea and Sequatchie Counties. As demonstrated in detail in response to **Question 4N** in the main application form, there is significant racial disparity for Black individuals being admitted to hospice care in the Service Area. This disparity surpasses both State and National metrics. Given the size of the Black population and that it represents approximately 11 percent of Service Area deaths, this disparity equates to between 224 and 259 annual underserved Black terminally ill patients in the Service Area.

The Applicant is both willing and able to serve, equally, the residents of the Service Area. That stated, its primary focus will be on the underserved Black population although it will admit all eligible patients without regard for race who seek Heritage Hospice's services. As reflected in response to **Question 6N** in the main application form, the Applicant forecasts admitting 55 Black patients of 108 to be admitted in year one (51 percent) and 128 Black patients of 222 to be admitted in year two (58 percent).

Heritage Hospice will methodically, creatively and effectively implement a Community Linkage Plan to lift up the Black hospice penetration in the ten-county Service Area. Special consideration should be afforded Heritage Hospice as it has demonstrated in this CON Application that the Black population's access to hospice services is limited within the Service Area, with disparities in contrast with the population counterparts averaging 20 to 25 percent during the past several years. With 74,000 Black individuals, nearly 10,000 Black elderly and more than 1,000 annual deaths, this equates to a significant number of Black terminally-ill individuals who are going without appropriate hospice services. Consumers will benefit from the education, outreach and collaboration with Heritage Hospice, community organizations, ministries and others with which Heritage Hospice will engage to lift up the Black hospice penetration rate in the Service Area.

Heritage Hospice will develop a set of tools and practices to address the cultural, health systems and other impediments to hospice care that confront the underserved population. It will increase awareness and understanding of advanced care planning, palliative care and hospice through culturally sensitive interventions. Heritage Hospice will formulate mechanisms that focus on building trust in the Black cohort and partnering with existing community resources that service the Black community such as Urban League, churches and community centers.

The many letters in support of Heritage Hospice's CON Application are submitted in **Attachment 1N-2** and speak to the racial disparity of Black individuals, unavailability of hospice services for this cohort, lack of education for this cohort and resulting low utilization. Approval of Heritage Hospice to establish this hospice to minimize racial disparities of hospice utilization will be a significant Consumer Advantage and Benefit.

Distressed Counties

Both Grundy County and Bledsoe County are two of ten distressed counties in Tennessee as it ranks among the top 10 percent of most economically distressed counties in the nation[2]. Each year, the Appalachian Regional Commission (ARC) prepares an index of county economic status for every county in the United States. Economic status designations are identified through a composite measure of each county's three-year average unemployment rate, per capita market income, and poverty rate. Based on these indicators, each county is then categorized as distressed, at-risk, transitional, competitive or attainment. Grundy County's current poverty rate is 20.5 percent of the population whereas Bledsoe is at 22.1 percent. Because Grundy County has no hospital, it is exempt from Certificate of Need requirements. It should be noted that while Grundy and Bledsoe Counties are categorized as distressed, four additional counties are classified as "at-risk" for becoming distressed. These are Meigs, Monroe, Rhea and Sequatchie Counties.

Heritage Hospice is fully committed to serving the ten Service Area counties equally; it is also committed to serving Grundy County via licensure (not via Certificate of Need process). The current racial disparities resulting in lower Black utilization of hospice services in the Service Area will be addressed through the approval of Heritage Hospice.

5. **Indigent Care:** The applicant should include a plan for its care of indigent patients in the Service Area, including:

    a. Demonstration of a plan to work with community-based organizations in the Service Area to develop a support system to provide hospice services to the indigent and to conduct outreach and education efforts about hospice services.
    b. Details about how the applicant plans to provide this outreach.
    c. Details about how the applicant plans to fundraise in order to provide indigent and/or charity care.

RESPONSE:

As a veteran of the industry, and a nurse, Ms. Hamilton is very familiar with meeting the needs of indigent patients in all service areas regardless of the patient's ability to pay. Working with minorities, community organizations, and qualified health centers, Heritage Hospice expects that it will admit several indigent patients. However, because the majority of patients are elderly, they typically are covered by Medicare and for some, dually covered by TennCare. As a result, true indigency and charity care is somewhat more limited in the hospice environment.

The Applicant's Community Linkage Plan, described in response to **Attachment 1N, Criterion #2,** demonstrates that it has a plan to work with community-based organizations throughout the Service Area to develop a support system to provide hospice services to all residents, including the indigent population, and its plan to conduct outreach and education about hospice services in this region.

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[2] Tennessee State Government via https://www.tn.gov/transparenttn/state-financial-overview/open-ecd/openecd/tnecd-performance-metrics/openecd-long-term-objectives-quick-stats/distressed-counties.html

Heritage Hospice has identified the below listed social service organizations with which it will effectively work to enhance access to hospice eligible populations including the underserved Black minority. It will coordinate and provide referrals to necessary social, economic and health services for patients and their families who need social and welfare service. These organizations provide a broad range of services beyond the scope offered by Heritage Hospice. By working with these organizations, Heritage Hospice will provide its patients and families with information and referral to appropriate social service organizations to the benefit of the community at large, including those who are indigent. The initial list of identified organizations, which will be supplemented once licensed and operational, are as follows.

- Urban League of Greater Chattanooga
- Churches, including Nivaq Ministries International
- Erlanger Health Centers
- Rural Health Clinics
- Homeless Shelters
- Churches
- Area Agency on Aging
- Senior Center
- Long Term Care Ombudsman Program
- Community Care Services Program
- Alzheimer's Association
- Arthritis Foundation
- Diabetes Foundation
- Heart Association
- Cancer Society
- Disabled Veterans

The Applicant will maintain regular communication with these agencies and others to be identified to assure it is an effective member of the community, with a comprehensive Community Linkage Plan. The Applicant will document the service linkage in the Heritage Hospice patient record and maintain periodic follow up with the referral organization. The Applicant will evaluate the effectiveness of the services, the patient/family satisfaction of the services and the coordination and communication of the services provided. Finally, the Applicant will report on its findings relative to the services provided and incorporate these findings into their regular QAPI meetings.

6. **Quality Control and Monitoring:** The applicant should identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. Additionally, the applicant should provide documentation that it is, or intends to be, fully accredited by the Joint Commission, the Community Health Accreditation Program, Inc., the Accreditation Commission for Health Care, another accrediting body with deeming authority for hospice services from the Centers for Medicare and Medicaid Services (CMS) or CMS licensing survey, and/or other third party quality oversight organization. The applicant should inform the HSDA of any other hospice agencies operating in other states with common ownership to the applicant of 50% or higher, or with common management, and provide a summary or overview of those agencies' latest surveys/inspections and any Department of Justice investigations and/or settlements.

Rationale: This information will help inform the HSDA about the quality of care the applicant's common ownership and/or management provides in other states and the likelihood of its providing similar quality of care in Tennessee.

RESPONSE:

As a newly formed legal entity, the Applicant does not have a history of providing care. However, concurrent with licensure and certification, the Applicant will develop all policies and procedures and its quality assurance program based on its experience in other markets and more importantly, its leadership's historical experience throughout the region. Its sample policies and quality assurance program are included in **Attachment 1N-6**. The samples provided include the following:

- Admission Process
- Initial/Comprehensive Assessment
- Intake Process
- Scope of Service
- Coordination of Care/Services
- Interdisciplinary Team (IDT) Meetings
- Interdisciplinary Team Plan of Care
- Nursing Services
- Spiritual Services
- Bereavement Services
- Admission Guidelines for Inpatient Services
- Admission for Respite Care
- Continuous Care Services
- Improving Organizational Performance

Heritage Hospice will be licensed by the Tennessee Health Facilities Commission/Licensure Division and will be certified by Centers for Medicare and Medicaid Services. Upon licensure and certification, the Applicant will adhere to all state and federal regulations and statutes and will comply with the Conditions of Participation for hospice providers of services under the Health Insurance for the Aged and Disabled Program (Title XVIII of the Social Security Act) and will participate in the TennCare/Medicaid Program. Heritage Hospice will seek CHAP accreditation as soon as it meets the minimum patient census to allow for CHAP accreditation survey; it expects this to occur within 90 days of licensure. CHAP accreditation assures its quality programming meets the highest standards.

Heritage Hospice will develop and maintain a Quality Assurance Performance Improvement (QAPI) Plan similar to the draft in the Attachment. The purpose of its QAPI Plan is to provide a strategy for the systematic organization-wide implementation of quality assessment and performance improvement activities. This ensures that the organization provides appropriate, high-value, effective and efficient services in accordance with its mission and current standards of practice. Through QAPI activities, Heritage Hospice will provide a mechanism for identification and prioritization of opportunities for problem identification and improvement in care and operations. The Applicant's QAPI Committee will identify and address quality issues and implement corrective action plans as necessary. From its draft QAPI Plan:

Mission

All QAPI activities must support and be aligned with the mission of the organization. The mission of the hospice is to provide compassionate, high quality healthcare for the best value, one person at a time, in their home setting. To carry out this mission, the hospice provides:

- A holistic program for the patient and family, caring for the physical, psychological and rehabilitative needs
- A dedicated team of health care professionals and staff who are qualified by experience and education
- Education to families, caregivers, and the community at large in the areas healthcare and chronic disease management in the home setting

Objectives

- To show measurable improvement in indicators that demonstrate an improvement in patient outcomes
- To measure, analyze and track quality indicators, including adverse events, to enable the assessment of processes of care, hospice services and operations
- To collect data to monitor the effectiveness and safety of services and quality of care as well as to identify opportunities for improvement
- To conduct Performance Improvement Projects aimed at performance improvement and to track performance to ensure that it is sustained
- To document QAPI activities including reasons for Performance Improvement Projects and progress achieved on these projects
- To keep current with monitoring of required quality measures; submit reports in mandated format within required timeframes

Methodology

The QAPI Plan is operated through a committee structure that ensures that the QAPI program follows regulatory requirements. The QAPI Chairperson (Coordinator) ensures that leadership priorities for improvement are evaluated. In addition, the QAPI Chairperson examines results from ongoing quality control activities to identify trends that will need follow*up action by the QAPI Committee.

The methodology selected to support and facilitate improvement activities is based on the Plan-Do-Study-Act (P-D-S-A) model. When an action for improvement is identified, an individual or project team may be designated to pilot the recommended action. A timeframe is established for implementing and evaluating the piloted action's outcome.

The effectiveness of any action will be assessed through a process that measures whether the performance expectations outlined in the action plan have been met. This may require additional data collection and analysis. Statistical analysis will be used in assessing performance outcomes.

Responsibility

The Executive Director will be the chairperson for the QAPI Committee and responsible for creating the QAPI culture, environment for change and facilitating quality assessment and performance improvement process. The Executive Director will also be responsible for selecting and appointing the committee members. The QAPI Committee will consist of the following representatives:

- Executive Director will serve as chairperson
- Director/ Professional of Clinical Services

- Medical Director
- 3-5 members of Heritage Hospice staff members

Resources will be made available to employees to assist them in gaining a basic understanding of QAPI principles. In-services will be held periodically to reinforce the knowledge base. Each employee is responsible for the quality of care and services provided.

The QAPI Committee will have the overall responsibility and authority to conduct a confidential review of information for the identification of concerns and trends for negative findings. The completion of tasks may be accomplished through designated individuals or quality project teams. Specific responsibilities will include:

- Ensuring the collection of accurate and reliable data
- Participating in cross-organizational activities to assess and improve overall organizational quality and performance
- Assisting in the implementation of corrective actions as appropriate
- Evaluating the effectiveness of planned and implemented actions
- Encouraging staff participation in improvement activities by mentoring; advancing education by acting as a resource to all staff
- Aggregating, trending and analyzing data using appropriate statistical techniques
- Ensuring timely data submission of required quality measures
- Reporting significant findings to appropriate managers, staff and governing bodies

A functional QAPI Committee is responsible for evaluating and prioritizing QAPI activities based on results of aggregated, analyzed data. This will ensure that the organization is providing appropriate, high-value, effective and efficient services in accordance with its mission and current standards of practice. Through QAPI activities, the organization provides a mechanism for identification and prioritization of opportunities for problem identification and improvement in care and operations. Requirements of the QAPI Committee will include the following:

- The QAPI Committee will meet monthly
- The chairperson will select a co-chair to act in the chairperson's absence and assist with the committee's work.
- Committee members will be required to attend regularly scheduled meetings
- That the QAPI Plan is ongoing, implemented and maintained
- That implemented QAPI activities address the appropriate priorities for the improved quality of care and patient safety
- Clear expectations for patient safety are met
- That all QAPI actions/changes are evaluated for effectiveness
- The QAPI Plan meets regulatory requirements

Managers and supervisors are responsible for providing leadership to ensure the communication and coordination of QAPI activities. Clinical and office personnel are responsible for participating in identifying opportunities for improvement through their daily contact with patients, physicians and other employees.

This QAPI Plan is effective because the QAPI efforts are grounded in the mission of the organization. The approach is a multi-disciplinary and collaborative one, and specific areas of responsibility are outlined. This QAPI Plan is founded on basic QAPI principles. It demonstrates that everyone in the organization is involved through their participation in a variety of QAPI activities. To accomplish this, the leaders provide education, resources in QAPI principles, and time to participate in QAPI activities.

The improvement methodology is identified to ensure a systematic approach to improvement efforts. There is a provision in the QAPI Plan to evaluate the effectiveness of the QAPI activities. This QAPI Plan demonstrates leadership involvement throughout the process. The Plan allows the flexibility needed if new problems or opportunities take priority.

The draft QAPI Plan is included in **Attachment 1N-6.**

7. **Data Requirements:** Applicants should agree to provide the Department of Health and/or the Health Services and Development Agency with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

RESPONSE:

The Applicant will provide the Tennessee Health Facilities Commission including any of its Divisions with all reasonably requested information and statistical data related to the operation and provision of services and will report the data in a timely manner and in the format requested.

8. **Education:** The applicant should provide details of its plan in the Service Area to educate physicians, other health care providers, hospital discharge planners, public health nursing agencies, and others in the community about the need for timely referral of hospice patients.

RESPONSE:

The Applicant will provide extensive community education activities surrounding the benefits of hospice to increase hospice awareness and utilization, how to dispel racial disparities, how to identify hospice appropriate patients, how to communicate with the patient and their family and the need for timely referral of hospice patients, consistent with leadership's experience. Leadership and direct hands-on staff will be cross trained to handle all outreach as needed. The team will be cognizant about racial disparities, dispelling myths, addressing barriers and educating referral sources, providers, families and patients. The ultimate objective and mission of Heritage Hospice is to lift up the hospice penetration rate for Black population to minimize and/or eliminate racial disparities in end of life hospice care.

Under Ms. Hamilton's leadership, the team will engage in outreach programs and coordinating educational sessions, presentations, and listening sessions with physicians, hospital discharge planners, nursing home discharge planners, and others. Additionally, they will educate skilled nursing facility, assisted living facility, hospital, and other healthcare provider constituents on the issues associated with racial disparities. The Applicant will host hospice educational events at the Urban League, veteran's organizations, senior organizations, religious affiliated groups, and health fairs. It will educate residents throughout the Service Area on the benefits of end-of-life care through hospice.

The Applicant's Community Linkage Plan presented in response to **Item #2, Criteria and Standards** is a comprehensive presentation of the Applicant's intent to educate community organizations, physicians, other healthcare providers, hospital discharge planners and community residents about hospice care, racial disparities, its plan to lift up Black hospice penetration and the need for timely referral of hospice patients. The detailed objectives and action steps incorporated into the Community Linkage Plan are specific and measurable. They demonstrate Heritage Hospice's knowledge of the underserved Black population, and how it will achieve success upon licensure and certification.

Criteria 9-16 only apply to Residential Hospice Services and are therefore not applicable to the Applicant.

ADDITIONAL SPECIFIC STANDARDS AND CRITERIA FOR HOSPICE SERVICES

17. **Need Formula:** The need for Hospice Services should be determined by using thefollowing Hospice Need Formula, which should be applied to each county in Tennessee:

    A / B = Hospice Penetration Rate

    Where:

    A= the mean annual number of Hospice unduplicated patients served in a county for thepreceding two calendar years as reported by the Tennessee Department of Health;

    and

    B = the mean annual number of Deaths in a county for the preceding two calendar yearsas reported by the Tennessee Department of Health.

    Note that the Tennessee Department of Health Joint Annual Report of Hospice Services defines "unduplicated patients served" as "number of patients receiving services on day one of reporting period plus number of admissions during the reporting period."

    Need should be established in a Service Area as follows:

    a. For a hospice that is initiating hospice services:

        i. The Hospice Penetration Rate for the entire proposed Service Area is less than 80% of the SMHPR;

    AND

        ii. c

    Preference should be given to applications that include in a proposed service area only counties with a Hospice Penetration Rate that is less than 80% of the **SMHPR;** however, an application may include a county or counties that meet or exceed the SMHPR if the applicant provides good reason, as determined by the HSDA, for the inclusion of any such county and: 1) if the HSDA finds that such inclusion contributes to the orderly development of the healthcare system in any such county, and 2) the HSDA finds that such inclusion is not intended to include a county or counties that meet(s) or exceed(s) the SMHPR solely for the purpose of gaining entry into such county or counties. Letters of support from referring physicians in any such county noting the details of specific instances of unmet need should be provided by the applicant.

Taking into account the above guidelines, the following formula to determine the demandfor additional hospice service recipients should be applied to each county, and the results should be aggregated for the proposed service area:

(80% of the Statewide Median Hospice Penetration Rate - County Hospice Penetration Rate) x B

Rationale - 17a: The Division believes that hospice services in Tennessee are under-utilized, most likely as a result of community and societal norms and a need for more education to the general public on the benefits of hospice. Consequently, the Division believes that hospice services should be encouraged, within reason, in Tennessee and that providing broader opportunities for these services will help educate the public as to their value. Under 17a, the ability to include within a service area a county that meets or exceeds the SMHPR should assist in the grouping of counties within a service area, thus providing more hospice services opportunities, provided that there is no detriment to the orderly development of the healthcare system as a result.

The Tennessee Hospice Association and other stakeholders provided information that 120 hospice service recipients is a larger than necessary number to ensure economic sufficiency of a hospice that is initiating hospice services. Consensus opinion appears to agree that 100 hospice service recipients is a sufficient number.

RESPONSE:

According to the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics, the 2020-2021 Hospice Rates and Projected Need report, the Hospice Penetration Rate at 80 percent shows an excess of 3,204 hospice admissions in the aggregated six county service area at 80 percent of the statewide median. This decreases to 2,982 hospice admissions at 85 percent. This formula does not consider specialized needs as enumerated herein. In fact, there is a documented and supported need for in-home hospice services for the Service Area's Black population. The referenced 2020-2021 Hospice Rates and Projected Need for the Service Area follows.

Hospice Rates and Projected Need

	Hospice Patients Served			Total Hospice Deaths*			Hospice Penetration Rate	Hospice Penetration Rate and Patient Need/(Surplus)	
County	**2020**	**2021**	**Mean**	**2020**	**2021**	**Mean**		***0.411***	***0.436***
Bledsoe	293	90	192	156	166	161	1.189	(125)	(121)
Bradley	703	890	797	1,289	1,481	1,385	0.575	(228)	(192)
Hamilton	3,356	3,961	3,659	3,852	4,163	4,008	0.913	(2,013)	(1,910)
McMinn	524	67	296	767	873	820	0.360	41	62
Marion	221	949	585	390	440	415	1.410	(415)	(404)
Meigs	159	137	148	171	195	183	0.809	(73)	(68)
Monroe	349	331	340	664	749	707	0.481	(50)	(32)
Polk	183	167	175	260	321	291	0.602	(56)	(48)
Rhea	351	364	358	471	523	497	0.719	(153)	(141)
Sequatchie	283	138	211	170	213	192	1.099	(132)	(127)
Service Area	6,422	7,094	6,758	8,190	9,124	8,657	0.781	(3,204)	(2,982)

*Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Death Statistical System, 2017-2021. Nashville, Tennessee. 2020-2021 JAR Hospice (not including Residential Hospice) data used for patient data, February 2023. Note: We believe the 2021 Hospice Patients Served for McMinn and Marion Counties in the above table are incorrect and should be 552 in McMinn (not 67) and 265 in Marion (not 949). These patient counts were aligned with other counties beginning with "M" on the State's report. The table with correct entries as adjusted by the Applicant is included in **Attachment 1N-17**.*

There are 14 licensed in-home hospice agencies serving the ten-county Service Area. Not all agencies serve all counties, and in fact one of these agencies had zero admissions from any Service Area county.

This CON Application is not being filed in response to the State's penetration and patient need analysis reflected in the above table. Rather it is being filed in direct response to the Service Area racial disparities identified and discussed throughout this CON Application. The need for this proposed hospice agency is evidenced by both qualitative and quantitative analyses. Additionally, the many letters of support that have been submitted in favor of Heritage Hospice speak to the racial disparities and the unique capabilities of Heritage Hospice to lift up the Black hospice penetration rate in the Service Area. Heritage Hospice's plan to educate and engage with the Black population, community organizations and referral sources will be a significant consumer advantage for Service Area minorities.

There are more than 74,000 Black individuals residing in the Service Area, with the majority residing in the two main population centers (Hamilton and Bradley Counties), and the balance dispersed throughout the other eight counties. While Blacks comprise about 10.5 percent of population, they comprise 11 percent of deaths, so a greater death rate than the remainder of the Service Area population. Furthermore, while comprising 11 percent of deaths, Blacks represent only 7.3 percent of hospice admissions further confirming a disproportionately low rate of Black hospice utilization.

Heritage Hospice will implement a culturally competent strategy to address the void in hospice services thereby enhancing accessibility and availability of hospice services for the Black terminally ill throughout the Service Area. It will also increase awareness and understanding of advanced care planning, palliative care and hospice through culturally sensitive interventions; and will focus on building trust in the Black cohort and partnering with existing community resources that service the Black community such as Urban League, churches and community centers.

Quantifiable need for this projected is derived from the 6 of the 18 letters of support for Heritage Hospice that identify racial disparity and the need for a hospice to address these disparities, 'unlike existing providers.' These letters specifically speak to the need for an additional ('new') hospice provider knowledgeable and experienced in providing culturally sensitive hospice care to Blacks and other minorities within the Service Area counties and request the HFC approve the Heritage Hospice CON Application. The outpouring of support for the project is representative of Service Area major health system, assisted living facilities, community organizations, physicians and nursing homes. The list of letter sponsors is presented below.

Health Systems and Physicians:

- Angel Moore, CEO, Erlanger Health Centers, Erlanger Health System
- Dr. Andrew Alward, NewTread Podiatry, Hamilton County
- Dr. Christopher Prater, Hamilton County
- Dr. Anthony G. Avitabile, Hamilton County

Nursing Homes and Assisted Living Facilities:

- The Waters of Sweetwater Rehab and Nursing Center, Monroe County SNF
- Decatur Wellness and Rehabilitation Center, Meigs County SNF

- Soddy Daisy Healthcare Center, Hamilton County SNF
- Morningside of Cleveland, Bradley County ALF
- The Lanterns Alzheimer's Center, Hamilton County ALF
- Brookdale Mount Vernon Drive, Bradley County ALF
- Dominion of Hixson, Hamilton County ALF
- Garden Plaza at Cleveland, Bradley County ALF
- American House Shallowford, Hamilton County ALF (two letters)
- American House Hamilton Place, Hamilton County ALF

Community Organizations/Persons:

- Urban League of Greater Chattanooga Area, Greg Funderburg, Marketing Director
- Nivaq Ministries International, Gavin Lynn Steward
- Smith Bone Consulting Group, Vickye Bone, Former VP Urban League of Greater Chattanooga

In terms of forecasted utilization and need for the hospice, while some letters of support indicate there is a need without quantifying the extent of patients/families to be referred to Heritage Hospice, others did in fact estimate the number of referrals to Heritage Hospice. These quantifiable estimates are identified below and in aggregate total between 120 and 144 annual admissions per year. Qualitative need provides for incremental admissions beyond that which is quantified in these letters and is discussed throughout this CON Application. Further, the racial disparity and associated needs analysis presented in response to **Question 4N** in the main application form provide support for the aggregate forecast.

Ray Allen, RN, LNHA, Administrator, Soddy Daisy Healthcare Center

"…I would expect between our facility physicians and our discharge planners to refer at least two patients per month to Heritage Hospice…"

Managing Member, Decatur Wellness and Rehabilitation Center, Meigs County

"…I would expect at least one referral per month from our facility and additional referrals from our physician…"

Pam Turley, RN, Administrator, Morningside of Cleveland, Bradley County

> *"...I would also anticipate them working with our medical director and case managers in assessing our residents likely resulting in a couple of referrals per month…"*

Brittany Sinclair, Resident Care Director, Garden Plaza at Cleveland, Bradley County

> *"…working with our medical director and case managers … likely resulting in a couple of referrals per month…"*

Lawrence Brewer, Community Relations Director, American House Shallowford, Hamilton County

> *"…Heritage Hospice has shared with me their plan to increase the African-American and Latino population in our area by enhancing access to hospice services through education, relationship*

> *building and high quality services in the person's home. We will support their efforts by referring 2-3 appropriate residents per month. …"*

Christopher Prater, MD, Hamilton County

> *"… Given their vision, I am in strong support for their Certificate of Need Application Approval to establish an additional hospice program in our community. Once approved, I expect I would refer one to two patients per month to Heritage Hospice. …"*

Based on the number of referrals estimated by just a few of the Heritage Hospice supporters, the forecasted admissions included in this CON Application (**Question 6N** of the main application form) are reasonable and achievable.

18. **Assessment Period:** After approval by the HSDA of a hospice services CON application, no new hospice services CON application - whether for the initiation of services or for the expansion of services - should be considered for any county that is added to or becomes part of a Service Area until JAR data for hospice services can be analyzed and assessed by the Division to determine the impact of the approval of the CON.

    Assessment Period Rationale: This Standard is designed to ensure that the impact of theprovision of hospice services as a result of the approval of a new CON is accounted for inany future need calculations for a Service Area.

RESPONSE:

There are no pending or approved certificates of need for hospice services in the ten-county Service Area. The existing licensed agencies throughout the Service Area have not been able to penetrate the Black population and eliminate, or at least minimize, racial disparities which are evident in both Medicare data and State data. By lifting up the Black hospice penetration rate throughout the Service Area, consumers will benefit through education, enhanced end of life services and improved quality on their final journey.

ATTACHMENT 1N-17

Restated TDOH Projected Hospice Need Table
With Correction to McMinn and Marion Counties

2020-2021 Hospice Rates and Projected Need

	Hospice Patients Served			Total Hospice Deaths*			Hospice Penetration Rate	Hospice Penetration Rate and Patient Need/(Surplus)	
County Name	2020	2021	Mean	2020	2021	Mean	Mean Number of Patients/Mean Number of Deaths	(Median Rate)*80% 0.411	(Median Rate)*85% 0.436
	Hospice Patients Served			Total Hospice Deaths*			Hospice Penetration Rate	Hospice Penetration Rate and Patient Need/(Surplus)	
County	**2020**	**2021**	**Mean**	**2020**	**2021**	**Mean**		***0.411***	***0.436***
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Bradley	703	890	797	1,289	1,481	1,385	0.575	(228)	(192)
Hamilton	3,356	3,961	3,659	3,852	4,163	4,008	0.913	(2,013)	(1,910)
McMinn	524	552	538	767	873	820	0.656	(201)	(180)
Marion	221	265	243	390	440	415	0.586	(73)	(62)
Meigs	159	137	148	171	195	183	0.809	(73)	(68)
Monroe	349	331	340	664	749	707	0.481	(50)	(32)
Polk	183	167	175	260	321	291	0.602	(56)	(48)
Rhea	351	364	358	471	523	497	0.719	(153)	(141)
Sequatchie	283	138	211	170	213	192	1.099	(132)	(127)
Service Area	6,422	6,895	6,659	8,190	9,124	8,657	0.769	(3,104)	(2,882)

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Death Statistical System, 2017-2021. Nashville, Tennessee. 2020-2021 JAR Hospice (not including Residential Hospice) data used for patient data, February 2023. Note: We believe the 2021 Hospice Patients Served for McMinn and Marion Counties in the above table are incorrect and should be 552 in McMinn (not 67) and 265 in Marion (not 949). These patient counts were aligned with other counties beginning with "M" on the State's report. The table with correct entries is included in ***Attachment 1N-17****.*

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

10-1-2022

ATTACHMENT 2N

Service Area Map

Heritage Hospice and Palliative Care

Project Service Area

🟩 CON Service Area

🟨 Distressed County to be Served

☐ Service Area

★ Heritage Hospice Office

06/11/2023

ATTACHMENT 4N

Articles Regarding Racial Disparity

Martina Orlovic, Katharine Smith and Elias Mossialos

Racial and ethnic differences in end-of-life care in the United States: evidence from the Health and Retirement Study (HRS)

Article (Published version)
(Refereed)

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Article

Racial and ethnic differences in end-of-life care in the United States: Evidence from the Health and Retirement Study (HRS)

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ABSTRACT

Population ageing poses considerable challenges to the provision of quality end-of-life care. The population of the United States is increasingly diverse, making it imperative to design culturally sensitive end-of-life care interventions. We examined participants of the Health and Retirement Study, who died between 2002 and 2014, to examine racial and ethnic differences in end-of-life care utilization and end-of-life planning in the United States. Our study reveals significant disparities in end-of-life care and planning among studied groups. Findings reveal that racial and ethnic minorities are more likely to die in hospital and less likely to engage in end-of-life planning activities. The observed disparities are still significant but have been narrowing between 2002 and 2014. Efforts to reduce these differences should target both medical professionals and diverse communities to ensure that improved models of care acknowledge heterogeneous values and needs of a culturally diverse US population.

1. Introduction

On average, more than 2.5 million people die every year in the United States (US), a number that is set to increase due to recent population trends (Kochanek, Murphy, Xu & Arias, 2017). Dying is inevitable, but care at the end-of-life is heterogeneous. End-of-life care includes not only pain and symptom management, but also provision of psychological, social, spiritual and practical support which may differ between cultural groups. There is a growing need for the US to meet the end-of-life care needs of an ethnically and racially diverse population. By 2050 there is estimated to be 33 million black American, Hispanic, Asian, American Indian or Alaskan Native individuals age 65 years and older. This represents nearly 40% of the population of this age group (Ortman & VelKoff, 2014). Culturally sensitive end-of-life care is one of the US national priorities, as identified by the National Consensus Project for Quality Palliative Care (National Consensus Project for Quality Palliative Care, 2018).

The delivery of end-of-life care is complex, involving public, private, and informal care providers. A successful health system supports the provision of patient-centered care: providing the right care at the right time and according to patient preferences (Wolf, Berlinger, & Jennings, 2015). Planning in advance for end-of-life care services is essential to support patient-centered care. It allows patients to die with dignity, taking into account their needs as well as the needs of their families and carers, and working in the context of scarce healthcare resources.

Health care disparities are extensively documented for African American and Hispanic people compared to whites in the United States across a range of diseases (Walkey et al., 2017). For example, African American and Hispanic people tend to receive fewer medical services and have less healthcare spending than white individuals (Walkey et al., 2017). It has been suggested that this pattern may be reversed at the end-of-life (Hanchate, Kronman, Young-Xu, Ash & Emanuel, 2009). Recently, growing body of literature offers population-level evidence on behaviors and care disparities among dying patients (Johnson, 2013). Research has demonstrated racial differences in aspects of end-of-life care, although the gap appears to be narrowing (Koss & Baker, 2017). Previous research has also found ethnic minorities to prefer more aggressive treatment at the end-of-life, compared to white people (Koss & Baker, 2017; Kwak & Haley, 2005). Research has differed in the causes they attribute to these differences. A number of studies found that cultural values, knowledge, and socio-economic status accounted for racial differences in possession of advance directives (Carr, 2012; Clark,

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Person, Gosline, Gawande & Block, 2018; Loggers et al., 2009; Smith, Earle, & McCarthy, 2009). More recently, studies found that, even accounting for confounding factors like these, the effect of race on possession of advance directives persists (Huang, Neuhaus, & Chiong, 2016).

Although the research on racial and ethnic end-of-life disparities is growing, there are still significant content gaps and methodological limitations (Johnson, 2013). Largely, the studies have been more focused on African Americans and less on Hispanics that form two largest minority groups in the US. Also, disparities in cancer patients have been studied more extensively, while there is less research focusing on other highly prevalent conditions such as cardiovascular or respiratory conditions. Further, many studies used convenience sample design which compromises generalizability of results. Finally, more research is needed on mediators of disparities among patients (Johnson, 2013). This paper makes a contribution to the literature by addressing the challenges of current body of literature and broadening the scope of previous research. It examines four hypotheses simultaneously, spanning health and retirement end-of-life care behaviors and practices in order to explain recent end-of-life trends in the general US population. Firstly, we hypothesize that African American and Hispanic people are more likely to die in hospital compared to white Americans. Secondly, we presume that non-white Americans are more likely to be exposed to more intensive treatments at the end-of-life compared to their white counterparts. This is likely due to a higher preference for life-prolonging treatments, lower medical literacy, lower uptake of newly developed end-of-life care policies, and unequal access to non-hospital end-of-life services (Barnato, Anthony, Skinner, Gallagher & Fisher, 2009; Crawley et al., 2000). Thirdly, we expect that African American and Hispanic individuals are less likely to be engaged in planning activities for the end-of-life than white Americans. Finally, attitudes towards end-of-life planning can also be influenced by religious beliefs, which is strongly related to individuals' cultural heritage (Kagawa-Singer & Blackhall, 2001; Phelps et al., 2009). In our fourth hypothesis, we expect that religion is an important factor in relation to end-of-life planning, irrespective of race and ethnic origin.

The study uses the Health and Retirement Study (HRS) – the largest longitudinal survey of a representative sample of Americans to examine nationwide cultural disparities in end-of-life care and planning. Even though the HRS has been used before, this is the first time it is used to provide an extensive insight into end-of-life care and planning, over more than a decade, and including not only clinical, but also individual characteristics, spanning from racial and ethnic origin to religiousness. Knowledge of disparities and social patterns of end-of-life care can support the design of policies to facilitate better access to end-of-life services across a diverse population and reduce existing differences.

2. Methods

2.1. Sample

Our analysis uses a sample of 9228 participants of the HRS, pooled across 6 survey waves, from 2002 to 2014. These periods were included because questionnaires in these survey waves included data on the presence of the living will. HRS is a nationally representative, biennial, longitudinal panel survey of individuals of 50 years of age and older, designed to study health and retirement among older people in the US (Bugliari et al., 2016). HRS, initiated in 1992, is based on in-depth interviews of more than 37,000 individuals on four major components of their lives: health, work and retirement, social connections and economic status. The survey is a rich data source which provides an insight into aging trajectories in America.

This analysis is based on HRS exit interviews, a special type of interview conducted with a proxy-respondent after the participant's death. The proxy-respondent is identified from the deceased's social network and is usually a close family member. The exit interview gives a detailed insight into the deceased's last year of life and death circumstances. Even though attrition is a common issue in longitudinal studies, that is minimized in the HRS due to frequent contact with study participants. Only 6.8% of study participants have dropped out due to attrition, while 36.8% have died since the beginning of the study (Fisher & Ryan, 2018). Exit interview is completed with almost all survey participants who died, ranging from 85.5% in 2002 to 97.9% in 2012 (Bugliari et al., 2016; Weir, 2016). Therefore, in the HRS mortality surveillance is considered complete (Weir, 2016).

2.2. Analyses

Analyses were performed using the statistical software STATA (Version 13). Multinomial logistic regression was employed to identify the impact of racial and ethnic background and patient characteristics on the place of death, a proxy for the intensity of end-of-life care. The outcome variable, place of death, had four possible categories: home, nursing home, hospice and hospital, the latter of which was a reference category. Explanatory variables included in the equation were racial and ethnic background (Non-Hispanic white, Non-Hispanic black, Hispanic white and other), age, gender, education level (lower than high school level, high school level, graduate level), income quintiles, cohabitation status, number of resident children, number of difficulties with activities of daily living (ADL), duration of terminal illness (less than a month, less than a year, more than a year), underlying cause of death (cancer, cardiovascular disease, allergies and pulmonary disease, disease of digestive system or other), number of health insurance plans, enrolment in Medicare fee-for-service (FFS) or Medicare health maintenance organization (HMO), presence of written end-of-life instructions, census region (North-East, Midwest, South, East), and a set of wave dummy variables to control for time trends. Non-Hispanic black refers to African Americans and Hispanic white refers to Hispanic individuals.

Additional outcomes were examined using logistic regression to better describe the intensity of end-of-life care. Adjusting for the same explanatory variables, the following binary outcomes were examined: short stay in hospital (less than a week), use of life support, use of kidney dialysis and time spent in an intensive care unit (ICU). These outcomes are established indicators of overly intensive end-of-life care (Gidwani-Marszowski et al., 2018). All outcomes describe individuals' healthcare utilization in their final moments of life.

The presence of written end-of-life instructions was used as an indicator of end-of-life planning. The initial model specification included the same explanatory variables as in the multinomial model. The second model specification included additional variables to identify the role of religion: religious adherence (often, sometimes and never) and religious importance (very important and not very important). Finally, the third model specification looked for interactions between racial/ethnic background and religious importance to determine whether the influence of race/ethnicity is a function of the individual's religiousness.

Furthermore, to better describe individuals' end-of-life preferences and planning activities, the following outcomes were assessed using logistic regression: end-of-life instructions express a desire to receive all care possible, end-of-life instructions express a desire to have any treatment withheld, last decisions involved withholding treatment, respondent had an end-of-life legal care arrangement, and weather respondent ever discussed end-of-life care. Finally, for those individuals who had written end-of-life instructions, and when the timing of these was known, adjusted average time for end-of-life planning was examined using regression analysis. This provides insight into the time when individuals engage in end-of-life planning activities as well as the importance of doing so. As HRS oversamples African American and Hispanic populations, respondent-level sample weights were applied to account for the unequal probabilities of selection between core and oversampled population. These sample weights are non-zero values for

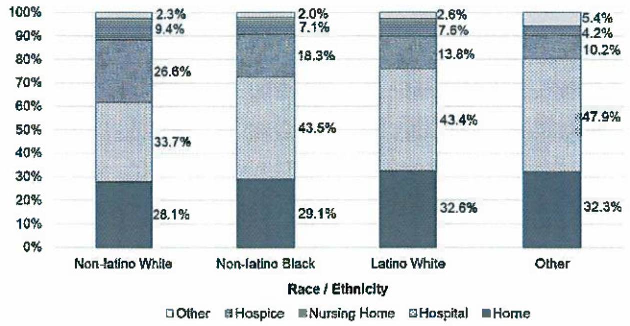

Exhibit 1. Place of death by race and ethnicity.

Source: Authors' analysis of data from the Health and Retirement Study, 2002–2014.

living respondents born in the particular year (Health and Retirement Study, 2002). As the analysis is using exit interviews, respondent-level weights for the wave prior death are used to obtain appropriate non-zero values. These HRS respondent-level weights are post-stratified to national totals and designed on the basis of birth cohorts for both genders and for each ethnic and racial group in order to capture the major characteristics of the sample design (Health and Retirement Study, 2002). That way, applied weights provide consistent adjustment for sample attrition and mortality (Health and Retirement Study, 2002).

3. Results

3.1. *Place of death and intensity of end-of-life care*

Descriptive results reveal a higher proportion of Non-Hispanic blacks (43.5%) and Hispanic whites (43.4%) who die in hospital compared to Non-Hispanic whites (33.7%) (Exhibit 1). Further, Non-Hispanic white Americans are more likely to die in nursing home (26.6%) compared to Non-Hispanic black (18.3%) and Hispanic white (13.8%) people. Although still existing, disparities in place of death have been narrowing between 2002 and 2014 (Appendix A). That is especially evident for deaths in hospice and hospital, while there is still significant and persisting difference in the proportion of deaths in nursing homes between white and non-white individuals. These findings were examined further using regression analyses.

A range of individual characteristics are associated with the place of death (Exhibit 2) Racial and ethnic differences persist even when adjusting for a range of individual confounders. Holding other variables constant, the odds of African Americans dying at home rather than in hospital are 23.2% lower compared to white Americans. Similarly, the same individuals are 35.5% less likely to die in a nursing home and 27.9% less likely to die in a hospice rather than in hospital, compared to their white counterparts. Further, Hispanics have 50.2% lower odds of dying in a nursing home rather than in hospital, compared to white Americans.

In addition to race and ethnicity, other individual characteristics also influence the site of death. Younger individuals, and those that suffer from short-term illnesses or experience an organ failure are more likely to die in hospital. In contrast, higher-income individuals, those who have in-house support or those who suffer from cancer are more likely to die outside of the hospital setting. Finally, individuals who have more insurance plans and are enrolled in a Medicare HMO plan are more likely to utilize non-hospital based end-of-life care, such as hospice or nursing home care. This is due to having a more comprehensive insurance package, different financial incentives and better affordability of out-of-hospital end-of-life care (Chen & Miller, 2017).

Additionally, a range of outcomes were assessed to better describe intensity of end-of-life care among individuals of diverse racial and ethnic background (Exhibit 3). African American and Hispanic people are more likely to be exposed to overly intensive care in the last moments of their life in terms of increased use of life support (OR(AA) = 1.49; OR(H) = 2.44) and use of kidney dialysis before death (OR(AA) = 1.79; OR(H) = 1.83) compared to white Americans. Also, African Americans are more likely to have a short stay (less than one week) in hospital before death (OR(AA) = 1.44), compared to the white

Exhibit 2

Multinomial logistic regression analysis of determinants of place of death.
Source: Authors' analysis of data from the Health and Retirement Study, 2002–2014.

Independent variable	Place of death (Sample = 6471)					
	Home		Nursing home		Hospice	
	RRR	P > |z|	RRR	P > |z|	RRR	P > |z|
Intercept	0.170	0.000***	0.004	0.002**	0.003	0.001**
Race/ethnicity (Ref: Non-Hispanic white)						
Non-Hispanic black	0.768	0.006**	0.645	0.000***	0.721	0.035**
Hispanic white	0.859	0.276	0.498	0.000***	0.913	0.689
Other	0.717	0.152	0.460	0.026**	0.451	0.139
Age	1.004	0.238	1.060	0.000***	1.030	0.000***
Gender (Ref: Male)	1.017	0.813	1.076	0.348	1.075	0.501
Education level (Ref: Lower than high school level)						
High school level	0.925	0.348	0.976	0.781	0.968	0.798
Graduate level	1.022	0.807	0.996	0.965	1.083	0.552
Income quintiles (Ref: 1st quintile)						
2nd quintile	1.080	0.485	0.920	0.448	1.102	0.576
3rd quintile	1.276	0.034**	0.974	0.825	1.333	0.107
4th quintile	1.232	0.092*	0.988	0.925	1.446	0.05*
5th quintile	1.347	0.023**	0.902	0.459	1.422	0.078*
Living with partner	0.970	0.670	0.398	0.000***	0.719	0.008**
Number of resident children	1.335	0.000***	0.314	0.000***	0.728	0.006**
Number of difficulties with ADLs	1.069	0.000***	0.979	0.075*	0.970	0.06*
Illness duration (Ref: Less than a month)						
Less than a year	1.613	0.000***	2.497	0.000***	1.928	0.000***
More than a year	2.447	0.000***	2.914	0.000***	1.987	0.000***
Cause of death (Ref: Other)						
Cancer	1.355	0.001**	0.482	0.000***	2.632	0.000***
Heart, circulatory and blood conditions	0.910	0.240	0.497	0.000***	0.821	0.132
Allergies; hay fever; sinusitis; tonsillitis	0.555	0.000***	0.387	0.000***	0.817	0.217
Digestive system	0.459	0.000***	0.323	0.000***	0.896	0.545
Number of health insurance plans	0.835	0.001**	1.253	0.000***	1.022	0.784
Medicare FFS /Medicare HMO	1.082	0.332	1.173	0.078*	1.382	0.006**
Respondent had written end-of-life instructions	0.990	0.883	1.062	0.424	1.451	0.000***
Region (Ref: North-east)						
Midwest	1.496	0.000***	1.430	0.001**	2.047	0.000***
South	1.552	0.000***	0.965	0.724	1.964	0.000***
West	1.834	0.000***	1.317	0.024**	1.260	0.226
Wave (Ref: Wave 6)						
Wave 7	0.938	0.587	0.968	0.792	1.517	0.059*
Wave 8	0.923	0.496	0.989	0.929	1.758	0.009**
Wave 9	1.156	0.223	1.243	0.086	2.888	0.000***
Wave 10	1.072	0.561	0.913	0.482	3.317	0.000***
Wave 11	1.363	0.014**	1.122	0.407	3.085	0.000***
Wave 12	1.157	0.239	1.229	0.127	2.927	0.000***

Notes: Presented results are from multinomial logistic regression analysis. Results are presented as relative risk ratios (RRR), indicating percentage relative risk change for a unit increase in the observed variable compared to the referent group, holding other variables constant. Base outcome is 'Dying in hospital'. $^{*}P < 0.1$, $^{**}P < 0.05$, $^{***}P < 0.001$. For categorical variables, reference category is stated in the row label, otherwise the reference is the complementary category.

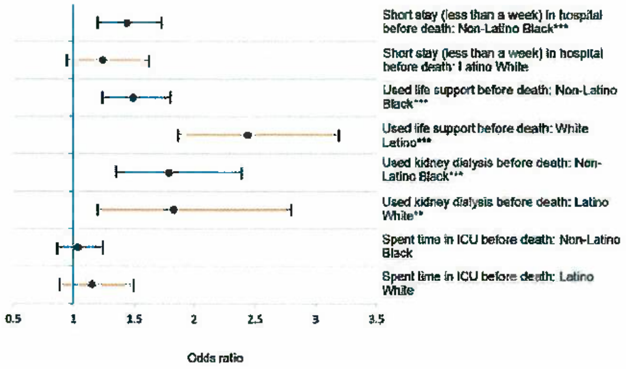

Exhibit 3. Differences in intensity of end-of-life treatment by race and ethnicity. Notes: The error bars indicate 95% confidence intervals. *P < 0.1, **P < 0.05, ***P < 0.001.

Source: Source: Authors' analysis of data from the Health and Retirement Study, 2002–2014.

population. This could be due to differences in their reasons for being in hospital. The data show that white Americans are more likely to be admitted to hospital for surgery, while African Americans are more likely to be in hospital to relieve symptoms. The full statistical output is shown in Appendix B.

3.2. *Planning for the end-of-life*

Race/ethnicity is an important determinant of end-of-life planning (Exhibit 4). African Americans (OR(AA) = 0.31) and Hispanics (OR (H) = 0.32) are significantly less likely than white individuals to have a living will. These differences persist even when adjusting for religious adherence and importance which are important characteristics of an individual's culture associated with a lower likelihood of having written end-of-life instructions. Further, individuals who were engaged in discussions around end-of-life care are significantly more likely to have written end-of-life instructions. Also, females, older, more educated, wealthier individuals, and those that suffer from cancer are more likely to plan for their end-of-life. Surprisingly, living with a partner or with children is associated with a lower likelihood of having written end-of-life instructions.

Multivariable analysis of secondary outcomes for end-of-life planning revealed that African American and Hispanic individuals are less likely than white individuals to engage in any type of end-of-life planning activities (Exhibit 5). Additionally, even when they plan for their death, the instructions are written on average 19 months closer to their death compared to those of white Americans. This suggests that white Americans place a higher value on and prioritize end-of-life planning more than other racial and ethnic groups. African American (OR(AA) = 0.50) and Hispanic individuals (OR(H) = 0.49), compared to their white counterparts, are unlikely to discuss their end-of-life care before death. Also, they are unlikely to have any legal arrangements regarding their care (OR(AA) = 0.36; OR(H) = 0.35) and it is unlikely that their decisions will involve withholding any treatment (OR(AA) = 0.46; OR(H) = 0.52). Non-white Americans express a strong preference to receive all care possible (OR(AA) = 2.25; OR(H) = 5.50) and to not have any treatment withheld (OR(AA) = 0.37; OR(H) = 0.52). Additional regression output is shown in Appendix C.

4. Discussion

This paper provides a comprehensive and up-to-date overview of end-of-life circumstances and planning for a representative sample of ethnically and racially diverse Americans. To the best of authors' knowledge, this is the first study that provides insight into determinants of the place of death, availability and the content of advance directives using 12 years of nationally representative data and examining simultaneously impact of various individual characteristics, ranging from racial and ethnic background to religiousness. People from minority groups in the US are more likely to die in a hospital setting and have more intensive treatments at the end-of-life compared to white Americans, which confirms our first and second hypothesis (Crawley et al., 2000; Institue of Medicine, 2015; Iwashyna & Chang, 1993). The differences persist even when accounting for the usual confounders. Previous research has suggested that higher rates of acute end-of-life care among minorities could exist for a variety of reasons spanning the social and the personal (Barnato et al., 2009; Kagawa-Singer & Blackhall, 2001). Certainly, racial and ethnic differences in the possession of resources go beyond income and education (Iwashyna & Chang, 1993). For example, African Americans and Hispanics generally live in larger households and are considered to have stronger social networks, which provides the opportunity to facilitate in-house death (Iwashyna & Chang, 1993). Further, Hispanic and African American families often rely on collective decision-making and family-oriented care, which could play a part in reducing a reliance on hospices and other long-term care services (Kagawa-Singer & Blackhall, 2001). Despite this, most minorities still die in a hospital setting and utilize overly intensive end-of-life care.

Long-term care availability, in terms of hospice and nursing homes, differs between rural and urban areas and lower utilization of such services has been documented for minorities compared to predominately white areas (Givens, Tjia, Zhou, Emanuel & Ash, 2010; Loggers et al., 2013). This indicates unequitable access to these services for minority populations and may contribute to higher use of acute end-of-life services in minority populations, since their choice of different types of end-of-life services is restricted. In addition, minorities are less likely to be informed about different care options at the end-of-life (Givens et al., 2010). Less informed individuals, especially those enrolled in FFS Medicare plans, may be more prone to the influence from medical professionals and supplier-induced demand (Chen & Miller, 2017). This may partly explain more intensive care at the end-of-life in minorities. Even though the differences exist, they appear to be narrowing due to public- and private- sector efforts in promoting the use of palliative care services and supporting related professional education and public engagement (Institue of Medicine, 2015; Koss & Baker, 2017). The number of Medicare beneficiaries enrolled into Medicare Hospice Benefit, a public insurance program intended for the last few months of beneficiary's life, more than doubled between 2000 and 2011, from 0.5 million to more than 1.2 million (Institue of Medicine, 2015). Further, studies have demonstrated cultural differences towards life-prolonging technology, attitudes and preferences for different end-of-life treatments and decision-making at the end-of-life (Kagawa-Singer & Blackhall, 2001). African Americans and Hispanics express a strong preference for intensive end-of-life care (Crawley et al., 2000). Even if intensive end-of-life care is a cultural choice, this may stem from mistrust in the healthcare system, perceived lower quality of care and unequitable access to necessary services throughout their lives (Crawley et al., 2000; Hanchate et al., 2009; Kagawa-Singer & Blackhall, 2001). According to the Agency for Healthcare Research and Quality (AHRQ), African Americans and Hispanics receive less preventive care, lower quality care and worse access to care (Agency for Healthcare Research and Quality, 2016). Consideration of different end-of-life care choices is facilitated by regular interactions with healthcare professionals; those without established care providers are unlikely to be aware of these choices.

Advance care planning is widely recognized as a beneficial mechanism for patients to maintain autonomy over their end-of-life care decisions because it allows patient preferences to be considered at a future date when patients are unable to express them (Institue of Medicine, 2015; Silveira, Kim, & Langa, 2010). It can take a number of forms including the living will and durable power of attorney. The HRS

Exhibit 4

Logistic regression analysis of determinants of end-of-life planning.

Source: Authors' analysis of data from the Health and Retirement Study, 2002–2014.

Independent variable	Presence of living will					
	OR (Sample = 6440)	P > |z|	OR (Sample = 4334)	P > z|	OR (Sample = 6300)	P > |z|
Intercept	0.015	0.000***	0.020	0.000***	0.016	0.000***
Respondent ever discussed end-of-life care	3.329	0.000***	3.547	0.000***	3.316	0.000***
Race/ethnicity (Ref: Non-Hispanic white)						
Non-Hispanic black	0.310	0.000***	0.319	0.000***	–	–
Hispanic white	0.316	0.000***	0.316	0.000***	–	–
Other	0.563	0.021**	0.739	0.288	–	–
Religious adherence (Ref: Often)						
Sometimes	–	–	0.852	0.102	–	–
Never	–	–	0.846	0.041**	–	–
Religious importance (Ref: Very important)	–	–	1.314	0.011**	–	–
Race/ethnicity # Religious importance (Ref: Non-Hispanic white, religion very important)	–	–	–	–	–	–
Non-Hispanic white # Religion not important	–	–	–	–	1.131	0.167
Non-Hispanic black # Religion very important	–	–	–	–	0.313	0.000***
Non-Hispanic black # Religion not important	–	–	–	–	0.301	0.002**
Hispanic white # Religion very important	–	–	–	–	0.318	0.000***
Hispanic white # Religion not important	–	–	–	–	0.387	0.012**
Other # Religion very important	–	–	–	–	0.493	0.003**
Other # Religion not important	–	–	–	–	2.060	0.010**
Age	1.026	0.000***	1.028	0.000***	1.026	0.000***
Gender (Ref: Male)						
Female	1.109	0.096*	1.067	0.392	1.112	0.095*
Education level (Ref: Lower than high school level)						
High school level	1.323	0.000***	1.366	0.000***	1.341	0.000***
Graduate level	1.722	0.000***	1.725	0.000***	1.747	0.000***
Income quintiles (Ref: 1st quintile)						
2nd quintile	1.310	0.004**	1.240	0.073*	1.308	0.005**
3rd quintile	1.526	0.000***	1.445	0.003**	1.493	0.000***
4th quintile	1.646	0.000***	1.544	0.001**	1.620	0.000***
5th quintile	1.831	0.000***	1.534	0.002**	1.764	0.000***
Living with partner	0.678	0.000***	0.767	0.003**	0.689	0.000***
Number of resident children	0.817	0.001**	0.832	0.014**	0.824	0.002**
Number of difficulties with ADLs	1.053	0.000***	1.049	0.000***	1.054	0.000***
Illness duration (Ref: Less than a month)						
Less than a year	0.975	0.721	0.944	0.504	0.966	0.632
More than a year	1.146	0.058*	1.130	0.160	1.141	0.07*
Cause of death (Ref: Other)						
Cancer	1.241	0.014**	1.147	0.194	1.259	0.009**
Heart, circulatory and blood conditions	1.020	0.795	0.976	0.791	1.024	0.756
Allergies; hay fever; sinusitis; tonsillitis	1.156	0.147	1.093	0.463	1.192	0.082*
Digestive system	1.118	0.350	1.066	0.657	1.168	0.200
Number of health insurance plans	1.233	0.000***	1.193	0.002**	1.232	0.000***
Medicare FFS /Medicare HMO	1.096	0.197	1.080	0.355	1.110	0.147
Region (Ref: North-East)						
Midwest	1.161	0.095*	1.125	0.285	1.184	0.064*
South	0.926	0.349	0.932	0.486	0.939	0.455
West	1.351	0.002**	1.344	0.015**	1.368	0.002**
Wave (Ref: Wave 6)						
Wave 7	1.125	0.257	–	–	1.159	0.169
Wave 8	1.286	0.016**	–	–	1.266	0.027**
Wave 9	1.206	0.073*	0.926	0.477	1.189	0.103
Wave 10	1.368	0.003**	1.039	0.724	1.359	0.004**
Wave 11	1.315	0.013**	0.977	0.835	1.295	0.021**
Wave 12	1.308	0.013**	1.008	0.943	1.305	0.016**

Notes: Presented results are from univariate logistic regression analysis. Results are presented as odds ratios, indicating percentage odds change for a unit increase in the observed variable, holding other variables constant. *$P < 0.1$, **$P < 0.05$, ***$P < 0.001$. For categorical variables, reference category is stated in the row label, otherwise the reference is the complementary category.

provides the opportunity to gain insights into advance care planning patterns of Americans, as it contains information on the availability and content of the living wills. Our findings indicate that African American and Hispanic individuals are less likely to engage in advance care planning, which confirms our third hypothesis. This is consistent with previous research that found that minority groups are less likely to have an advance directive or a healthcare proxy compared to white people (Huang et al., 2016; Institue of Medicine, 2015; Kagawa-Singer & Blackhall, 2001; McAfee, Jordan, Sheu, Dake & Kopp Miller, 2017). Also, religion is an important determinant of end-of-life planning. More religious individuals are less likely to engage in end-of-life planning activities, a finding that confirms our fourth hypothesis. Religious

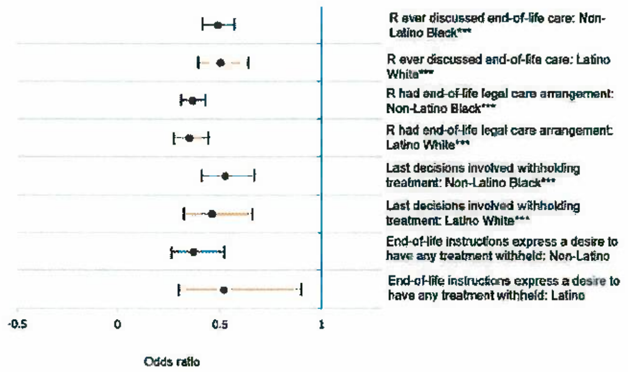

Exhibit 5. Differences in end-of-life planning by race and ethnicity. Notes: The error bars indicate 95 percent confidence intervals. $*P < 0.1$, $**P < 0.05$, $***P < 0.001$. R denotes the respondent.
Source: Authors' analysis of data from the Health and Retirement Study, 2002–2014.

individuals may describe pain and suffering as something that must be endured, not avoided and that only God has the power to make decisions about ending life (Fang, Sixsmith, Sinclair & Horst, 2016; Kagawa-Singer & Blackhall, 2001). Even though religion is an important factor in end-of-life planning, differences in religion do not account for or explain the differences observed between racial/ethnic groups.

Previous research has highlighted reasons for these racial and ethnic disparities in engaging with advance care planning. Mistrust in healthcare professionals and the health system more generally, perhaps due to previous mistreatment, is a frequently expressed explanation (Institue of Medicine, 2015; Kagawa-Singer & Blackhall, 2001; McAfee et al., 2017). In fact, African Americans are more likely to believe they would be given poorer-quality medical treatment and be treated differently if they completed an advance care directive (Clark et al., 2018; Kagawa-Singer & Blackhall, 2001; McAfee et al., 2017). Also, it has been suggested that a lack of knowledge of advance care planning as well as lower health literacy are reasons for low completion of living wills among minorities (Bullock, 2006; Kermel-Schiffman & Werner, 2017). Another explanation could be that collective decision-making is more prevalent in cultures of observed minorities which could emphasize the role of family input into end-of-life care and be a reason for greater reluctance among minorities to have a living will (Clark et al., 2018). Further, having an end-of-life discussion substantially increases the likelihood of having a living will. In our dataset, however, among those who had a conversation about their end-of-life wishes, only 12% were African American and 6% were Hispanic. While this may reflect reluctance among minorities to engage in such activities, in addition there may be significant access barriers to these types of services. Since 2016, Medicare reimburses physicians for these conversations, which may reduce access barriers for minorities and improve completion rates of advance directives (Griffin et al., 2016). Preferences in terms of withholding treatment also differ along cultural lines. Compared to white Americans, minorities express a strong desire to receive all care possible and not to have any treatment withheld at the end of life. This further strengthens perceived mistrust in the healthcare system. Language barriers and a lack of familiarity with the healthcare system can further deepen access barriers for minorities and discourage them from end-of-life planning (Burdsall, 2013).

4.1. *Limitations*

The analysis is based on data obtained from proxy-respondents which may be subject to response bias and loss of information. The HRS does not verify the accuracy of information against Medicare records (Chen & Miller, 2017). However, the majority of proxy-respondents (88%) are close family members, so are likely to be aware of the end-of-life circumstances of their loved ones. Also, although mortality ascertainment in the study is considered high-quality and complete (Weir, 2016), small proportion exit interviews could not be carried out which may undermine results representatives. Further, the HRS provides limited information about the intensity of end-of-life care, so more comprehensive analysis could not be conducted. Future research should include Medicare claims data to examine the type and intensity of care in more detail. The survey is not designed to assess quality of care and does not provide adequate information about it, so we were only able to observe racial and ethnic differences in types of end-of-life care received. Also, the survey does not provide data on the characteristics of individuals' living settings and we were unable to control for the availability of acute and long-term care services, which may impact healthcare utilization at the end-of-life (Orlovic, Carter, Marti & Mossialos, 2017). Additionally, information on the level of health literacy, which may be important for discerning end-of-life preferences and recording end-of-life instructions, was unavailable (Smith et al., 2009). The HRS provides limited information on local and regional differences in available health care resources which may be important in explaining differences in end-of-life care utilization (Keating et al., 2018; Tschirhart, Du, & Kelley, 2014). Even though we control for a range of individual characteristics that may impact end-of-life circumstances, some important determinants of end-of-life care may remain unobserved. Finally, the study has cross-sectional design, which limits the ability to make causal inferences.

4.2. *Policy implications*

Advance care planning is an important part of the provision of patient-centered and cost-effective care (Boerner, Carr, & Moorman, 2013). An understanding of patient pathways at the end-of-life facilitates access to timely end-of-life care which can improve health outcomes, prevent over treatment and ensure cost-effective use of healthcare resources. National investments in long-term care infrastructure could increase access to alternative, out-of-hospital types of end-of-life care, enabling more comprehensive public support for terminally ill patients of all cultural groups (Mack, Weeks, Wright, Block & Prigerson, 2010). Also, financial incentives and organizational arrangements should be designed in a way to prevent supplier-induced demand. That requires alternatives to FFS reimbursement such as development of accountable care organizations, bundled payments, or introducing penalties for high 30-day readmission rates, hospital mortality, and poor patient experience (Institue of Medicine, 2015). Expanding insurance coverage to include additional long-term care services is worthwhile because it could reduce the pressure on acute end-of-life services, but in the context of rising healthcare costs it will be challenging to secure public support for these services. Further, recorded end-of-life preferences are associated with better quality end-of-life care (Mack et al., 2010; Teno, Gruneir, Schwartz, Nanda & Wetle, 2007). Policies should ensure equitable access to care throughout an individual's life, not only as it ends. Also, special attention should be given to familiarizing minorities with different treatment options at the end-of-life and with the benefits of advance care planning. This could be achieved with culturally-tailored community-based interventions. Further, clear communication from healthcare professionals, both to patients and to their families, is of crucial importance. In cases where preferences are based on well-informed decisions, these should be considered and approached in a culturally-sensitive way. This may require additional education of healthcare professionals, so they can be better equipped to work with culturally diverse populations. These actions could improve overall medical literacy of minorities, perceived care quality and satisfaction, and trust in the healthcare system.

5. Conclusion

This study provides an analysis of end-of-life circumstances of the American population. There are marked racial and ethnic disparities at the end-of-life, even when adjusting for a range of individual characteristics. The demand for culturally-sensitive end-of-life care will continue to rise due to a growing ethnically and racially diverse population of older adults. Efforts to reduce existing discrepancies should target both patients and healthcare professionals to ensure that new models of care accommodate the diverse needs of older adults. Securing these conditions for high-quality end-of-life care is likely to require dedicated support from governmental structures. The millions of Americans that deal with life-threatening conditions deserve access to adequate patient-centered end-of-life care.

Declaration of interest statement

None.

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Appendix A. Supplementary material

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.ssmph.2018.100331.

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Racially Associated Disparities in Hospice and Palliative Care Access: Acknowledging the Facts While Addressing the Opportunities to Improve

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In February 2004 more than 500 individuals met in Atlanta for an historic conference, The Last Miles of the Way Home.[1] This landmark national conference supported by the Robert Wood Johnson Foundation through its Last Acts® campaign was the first of its kind giving voice to issues in end-of-life decision making and caregiving unique to African American patients, families, and communities. A major motivation to hold this meeting was to address the accumulating observations that racial and ethnic factors were important to determining disparities or differences in access to hospice and palliative care services, and the quality of care for those experiencing the services.[2] According to the Medicare Payment Advisory Commission in the year 2000, only 17% of Medicare decedents who used hospice were African American, compared to 23.8% who were white and 24.1 Hispanic. Although the use of hospice among Medicare decedents in all racial groups increased between the years 2000–2015, there is still nearly a 12-point difference between whites and African American hospice use.[3] Current data from the National Hospice and Palliative Care Association (NHPCO) also documents persistent racial and ethnically based disparities in hospice use between blacks and whites, with at least 8.4% of all hospice patients identified as black or African American (with another 7.4% of patients identifying as "multiracial or other race"), compared to 80.9% white or Caucasian.[4] This difference in hospice use is even more striking given that African Americans have excessive mortality from almost all causes of death, including hospice-appropriate illnesses.[5]

There is much evidence that palliative care improves the quality of life of seriously ill patients and families,[6] in cost-effective ways.[7] However the Institute of Medicine (now renamed The National Academy of Medicine) criteria for quality care requires evidence of equitable care—in addition to care that is safe, effective, timely, and patient-centered. Currently there is very little data relating to how equitable nonhospice palliative care services are. What little evidence there is suggests that there are minimal differences in access to inpatient palliative care services between racial groups,[8] although one study reported a greater symptom burden and persistence of cancer-related symptoms in African Americans and Hispanics, compared to whites cared for in an outpatient setting.[9]

Many factors account for disparities in hospice use, and in the differences between blacks and whites reported in the experience and outcomes of palliative care services more generally.[10] Among the most important factors are (1) those based on influences of cultural beliefs and preferences[11]—in particular values and beliefs that are strongly influenced by religious beliefs[12] that challenge the typical assumptions of advance care planning to limit medical interventions in terminally ill patients[13] and (2) a preference for more "aggressive" care by African Americans when seriously ill—a preference that is greatly influenced by cultural and religious values and perspectives.[14]

There is a strong consensus in the hospice and palliative care community that advance care planning is a good thing because it allows a process for patients and families to consider their preferences and values that should guide care for them at the end of life. Although blacks show a higher preference than whites to die in hospital (as opposed to home), it is still true that a majority of African American Medicare beneficiaries still prefer to die at home.[15] This preference for home care by the majority of African Americans Medicare beneficiaries should favor greater hospice use, and should be supported by written directives and instructions to health care surrogates, when they are available. Of note, a study by the California Healthcare Foundation noted that even though African Americans had less knowledge about advance care planning than other minority groups in California, they also had fewer negative attitudes about the concept than did other racial/ethnic groups in the study.[16]

African Americans are highly religious. A recent report from the Pew Research Foundation observed that "African Americans are markedly more religious on a variety of measures than the U.S. population as a whole, including level of affiliation with a religion, attendance at religious services, frequency of prayer, and religion's importance in life. Compared with other racial and ethnic groups, African Americans are among the most likely to report a formal

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religious affiliation, with fully 87% of African Americans describing themselves as belonging to one religious group or another."[17] Religious-based concerns about the morality of advance care planning, and culturally based apprehensions about the motives of those promoting advance care planning, alarm many African Americans. For example, a survey of 205 African American patients at the Duke University Health System showed that "African Americans were more likely to express discomfort discussing death, want aggressive care at the end of life, have spiritual beliefs that conflict with the goals of palliative care, and distrust the health care system."[18] A systematic literature review also supports the observations concerning religious and spiritual views of African Americans that strongly endorse beliefs in miracles and the notion that only God can determine life and death.[19]

So, what is the way forward? A belief in fatalism and a desire to pursue aggressive medical care as a sign of faithfulness to Christian beliefs that honor preservation of life often drive medical decisions to delay hospice referral for many African American patients and families. However, it appears that these religious beliefs can be addressed by skillful medical teams in ways that can accommodate these spiritual views and lead to less aggressive hospital care at the end of life, even in patients who report strong support from religious communities. For example, Balboni et al. found that when spiritual support and end-of-life conversations were directed by medical teams to patients with advanced cancer who reported "a high degree of spiritual support from religious communities," these patients had *greater odds* of receiving hospice care and *lower odds* of dying in an ICU when compared to similar patients who did not receive the medical team support. [20] This was the case, *in particular*, for racial/ethnic minority patients in their study.

These findings indicate that medical teams have an important role to play in helping strongly religious patients reframe the meaning of their spiritual beliefs in the context of their particular medical circumstances in ways that do not exclude care in hospice and palliative care settings. The positive influence of medical teams on end-of-life choices provide support for recommendations to modify hospice eligibility to enable so-called concurrent care models such as being studied in the Medicare Care Choices Model now being launched by The Centers for Medicare & Medicaid Services (CMS).[21] The Medicare Care Choices Model is evaluating whether disease modifying treatments when combined with traditional hospice services will improve quality of life of patients with serious and terminal medical illness. Dissemination of concurrent care models should reduce disparities between whites and blacks in access to hospice and palliative care services, since they should address the strong preferences for continuation of medical treatments so often requested by African American—a factor that has been documented as an important factor in the persistence of this inequality.[14,22]

Serious engagement with the religiously minded majority of African Americans to promote earlier referral to palliative care and hospice, longer lengths of stay, and fewer withdrawals from hospice care requires partnerships between community-based clergy, chaplains, and hospice personnel that provide ongoing conversations and education to engage deeply specific aspects of theology and religious belief. This may be promoted by disseminating community-based support team models that partner spiritual leaders and peers of the patient with hospice and palliative care team providers focused on meeting the emotional and spiritual needs of African Americans with serious illness.[23] This will require commitments to ongoing and truly intraprofessional education of health care providers, chaplains, and community-based pastors to assure a common understanding of the medical issues faced by terminally ill African Americans and their theological interpretations of their life and illness experiences.

In addition to lack of information, misperceptions about the motives of providers and medical institutions advocating for advance care planning and greater hospice use is another factor driving disparities. This is supported by studies showing racial differences in knowledge about hospice care.[24] Thus use of nonconventional strategies for soliciting and preserving the patient's voice, such as letter writing[25]and videotaping,[26] are simple tools that allow direct and nuanced communications between patients and doctors that cut across levels of health literacy, and should be used more commonly to facilitate communication with African Americans and other racial/ethnic minorities. Thoughtful, well-constructed education programs that provide practical information about what palliative and hospice services offer, that address misconceptions about the care provided, and that are delivered by trusted sources in the community with attention to social and spiritual needs of patients and families may be successful in increasing participation in advance care planning and earlier use of palliative and hospice care. If lower rates of hospice use and other disparities persist despite use of innovative communication and educational efforts, then at least one would have greater confidence that these decisions are based on a more informed knowledge base.

There is a wise saying: "Every man is in certain respects like all other men, like some other, and like no other man."[27] Respecting and responding appropriately to these three aspects of a person's identity poses a challenge to providing truly personalized quality palliative and hospice care—care that is safe, effective, patient-centered, timely, efficient, and equitable.[28] In addressing African American patients and families, these challenging goals can be accomplished by a commitment to acknowledging the pernicious effects of past and present racism, learning and respecting cultural and religious values, and expanding a commitment to continuous improvement in communication between providers and patients. Furthermore, there must be a commitment to strategic and creative engagement with community partners to delivery of truly comprehensive care that focuses on the well-being of persons throughout illness in body, mind, and spirit.

There is another wise saying, attributed to Thomas Jefferson, that goes, "Do you want to know who you are? Don't ask. Act! Action will delineate and define you."[29] This is great insight and good advice indeed for all in our hospice and palliative care community committed to provide the best care possible for all persons suffering with serious illness. We must not waver from the ongoing hard work of assuring equal access and the best possible outcomes for everyone who needs hospice and palliative care. This will be key in defining the great goals and purposes of our palliative care field.

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Evaluation of Racial Disparities in Hospice Use and End-of-Life Treatment Intensity in the REGARDS Cohort

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Abstract

IMPORTANCE Although hospice use is increasing and patients in the US are increasingly dying at home, racial disparities in treatment intensity at the end of life, including hospice use, remain.

OBJECTIVE To examine differences between Black and White patients in end-of-life care in a population sample with well-characterized causes of death.

DESIGN, SETTING, AND PARTICIPANTS This study used data from the Reasons for Geographic and Racial Differences in Stroke (REGARDS) study, an ongoing population-based cohort study with enrollment between January 25, 2003, and October 3, 2007, with linkage to Medicare claims data. Multivariable logistic regression models were used to examine racial and regional differences in end-of-life outcomes and in stroke mortality among 1212 participants with fee-for-service Medicare who died between January 1, 2013, and December 31, 2015, owing to natural causes and excluding sudden death, with oversampling of Black individuals and residents of Southeastern states in the United States. Initial analyses were conducted in March 2019, and final primary analyses were conducted in February 2020.

MAIN OUTCOMES AND MEASURES The primary outcomes of interest were hospice use of 3 or more days in the last 6 months of life derived from Medicare claims files. Other outcomes included multiple hospitalizations, emergency department visits, and use of intensive procedures in the last 6 months of life. Cause of death was adjudicated by an expert panel of clinicians using death certificates, proxy interviews, autopsy reports, and medical records.

RESULTS The sample consisted of 1212 participants (630 men [52.0%]; 378 Black individuals [31.2%]; mean [SD] age at death, 81.0 [8.6] years) of 2542 total deaths. Black decedents were less likely than White decedents to use hospice for 3 or more days (132 of 378 [34.9%] vs 385 of 834 [46.2%]; $P < .001$). After stratification by cause of death, substantial racial differences in treatment intensity and service use were found among persons who died of cardiovascular disease but not among patients who died of cancer. In analyses adjusted for cause of death (dementia, cancer, cardiovascular disease, and other) and clinical and demographic variables, Black decedents were significantly less likely to use 3 or more days of hospice (odds ratio [OR], 0.72; 95% CI, 0.54-0.96) and were more likely to have multiple emergency department visits (OR, 1.35; 95% CI, 1.01-1.80) and hospitalizations (OR, 1.39; 95% CI, 1.02-1.89) and undergo intensive treatment (OR, 1.94; 95% CI, 1.40-2.70) in the last 6 months of life compared with White decedents.

CONCLUSIONS AND RELEVANCE Despite the increase in the use of hospice care in recent decades, racial disparities in the use of hospice remain, especially for noncancer deaths. More research is required to better understand racial disparities in access to and quality of end-of-life care.

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Key Points

Question Are there differences between Black and White patients in the use of hospice and intensity of end-of-life treatment?

Findings In this cohort study of 1212 decedents, Black individuals were significantly less likely to use hospice and more likely to have multiple emergency department visits and hospitalizations and undergo intensive treatment in the last 6 months of life compared with White individuals regardless of cause of death.

Meaning Despite the increase in the use of hospice care in recent decades, racial disparities in the use of hospice care and the intensity of end-of-life treatment remain.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Introduction

Consistent with patient preferences to avoid intensive hospital-based care at the end of life,[1,2] in 2017, most US patients died at home.[3] Use of hospice care is on the rise in the United States—with most deaths of Medicare beneficiaries occurring while receiving hospice care, a significant increase in the last decade.[4] The fastest-growing segment of the population receiving hospice care includes individuals with noncancer diagnoses.[5] Despite the potential benefits of hospice enrollment for individuals and families, including enhanced quality of life for patients near the end of life[6-8] and decreased Medicare costs,[9] half of patients with terminal illnesses still do not use hospice care.[10] Furthermore, most individuals who use hospice care are admitted very close to the end of life. Short hospice stays (≤3 days) have increased to 28.4% of all hospice stays,[10] and 14.3% of patients with cancer who enroll in hospice do so in the last 3 days of life.[11] In addition, high-intensity treatments at the end of life remain common despite patient preferences to avoid such care. For example, among Medicare beneficiaries, intensive care unit use in the last month of life increased from 24% in 2000 to 29% in 2015.[4]

Research has documented racial differences in hospice use and end-of-life treatment intensity, consistent with a broad range of racial disparities in health care use and health outcomes. In general, Black decedents receive more aggressive care, have higher end-of-life health care spending, and are less likely to use hospice services than White decedents.[12-14] Reasons for these disparities include preferences for more aggressive care, mistrust of the health care system, lack of in-home resources, and miscommunication and misunderstanding of treatment options.[15]

Because substantial shifts in end-of-life health care delivery have occurred, it is critical to better understand whether similar racial differences persist in the setting of different diseases. We used the Reasons for Geographic and Racial Differences in Stroke (REGARDS) study linked to Medicare claims data to examine disparities in end-of-life care among individuals who have died of stroke, heart disease, cancer, dementia, or other serious illnesses. We hypothesized that high-intensity treatments at the end of life will be more common among Black than White decedents and that Black decedents will be less likely to use hospice care regardless of the cause of death.

Methods

Data Sources and Study Population

The data for this study are from REGARDS, an ongoing population-based cohort study of racial and regional differences in stroke mortality, with oversampling of Black individuals and residents of Southeastern states in the United States. The recruitment, enrollment, and assessment procedures of this national, population-based study are described in detail elsewhere.[16] A total of 30 239 adults 45 years or older were enrolled between January 25, 2003, and October 3, 2007. Exclusion criteria included residence in or on a waiting list for a nursing home; cancer diagnosis requiring active treatment, such as chemotherapy or radiotherapy; and not speaking English. Every 6 months, follow-up telephone interviews are conducted with REGARDS enrollees to inquire about hospitalizations, outpatient visits, and any symptoms that might indicate possible study end points (eg, stroke and myocardial infarction). All REGARDS participants signed written informed consent statements that authorized the investigators to access their medical records to detect possible strokes, myocardial infarctions, and other medical events. This included permission to access electronic and administrative medical records, including Medicare claims. Medicare claims files have been successfully linked to REGARDS participants[17] and examined in previous analyses of health care use.[18,19] The REGARDS participants who died between January 1, 2013, and December 31, 2015, were included in this study, and the study was reviewed and approved by the institutional review boards of the University of Alabama at Birmingham and Johns Hopkins University. This report followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.[20]

Outcome Measures

Our primary outcomes of interest were hospice use and other measures of end-of-life treatment intensity within the last 6 months of life.[21] All outcome variables were derived from Medicare fee-for-service (parts A and B) claims files. We focused on hospice use of 3 or more days as our primary measure to avoid capturing suboptimal hospice use owing to short duration.[7] Next, building on previous work,[22-24] we identified the use of 1 or more intensive life-sustaining medical procedures as determined by a review of *International Classification of Diseases, Ninth Revision* (*ICD-9*) codes or *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* (*ICD-10*) codes in each decedent's Medicare claims. These procedures included intubation and mechanical ventilation, tracheostomy, gastrostomy tube insertion, enteral or parenteral nutrition, hemodialysis, and cardiopulmonary resuscitation. Finally, we counted the number of emergency department (ED) admissions and inpatient hospitalizations in the 6-month period before death. Our primary focus was 2 or more ED visits and 2 or more hospital stays.

Main Exposure

Race in REGARDS is determined by self-report. Because the REGARDS study was designed to examine the factors that might explain the increased stroke mortality previously observed for Black individuals, only Black individuals and White individuals, who served as the reference group, were enrolled, and individuals who self-identified as Hispanic, Latino, Asian, or other races/ethnicities were excluded.

Covariates

Cause of death in the REGARDS study is adjudicated by an expert panel of clinicians using methods that are consistent with American Heart Association consensus guidelines.[25,26] Death certificates, autopsy reports, and medical records from hospitalizations in the last 6 months of life were retrieved. Participant proxies (next of kin, family members, or close friends) were also interviewed to obtain information about the events surrounding the death. Each death is adjudicated independently by 2 expert clinicians who conduct their reviews using all information available at the time of review, including the participant's clinical baseline characteristics, death certificates, proxy interviews, the National Death Index, and medical records from recent hospital admissions. After individual review, the adjudicators agree on the underlying cause of death. Disagreements are resolved by consensus. Because of our interest in the decision to use hospice services, we excluded individuals who were determined by the adjudication panel to have experienced sudden death or death due to unnatural causes (10.8% [146 of 1358] of all deaths). For the present analyses, we grouped cause of death into the following 4 categories: cancer (all types); dementia; cardiovascular disease (CVD), including myocardial infarction, heart failure, stroke, and pulmonary embolism; and other, which included causes such as end-stage kidney disease, liver disease, infection, respiratory disease, and other medical problems not considered to be sudden deaths.

Demographic variables (sex, date of birth, marital status, annual household income, and educational level) were collected from a computer-assisted telephone interview conducted by trained interviewers at the time of enrollment into REGARDS. Location of residence was categorized based on census region and whether it was in the southern "stroke belt" region of the United States (1 of 8 states [North Carolina, South Carolina, Georgia, Tennessee, Alabama, Mississippi, Arkansas, and Louisiana] with high stroke mortality). The Charlson Comorbidity Index score was calculated using *ICD-9* and *ICD-10* diagnosis codes from the inpatient, outpatient, and physician claim (carrier) files for the 6-month period preceding death. These codes were then mapped to 17 comorbid conditions, weights were assigned, and the index was calculated.[19] Medicaid dual-eligibility status was obtained from the Medicare beneficiary enrollment file.

Statistical Analysis

Initial analyses were conducted in March 2019, and final primary analyses were conducted in February 2020. Based on a conceptual framework of treatment intensity for patients with serious illness[27] and a review of the literature, we first compared key clinical and demographic characteristics and markers of end-of-life treatment intensity by race. We used the χ^2 test, the *t* test, and the Wilcoxon rank sum test as appropriate. After stratifying by cause of death, we examined racial differences in markers of end-of-life treatment intensity. Next, we used multivariable logistic regression to examine the association of race with each of 4 outcomes: (1) hospice use of 3 or more days, (2) multiple ($\geq$2) ED visits in the last 6 months of life, (3) multiple ($\geq$2) hospital stays in the last 6 months of life, and (4) any use of intensive treatments in the last 6 months of life. Each model was adjusted for cause of death, sex, marital status, educational level, income, Charlson Comorbidity Index score, age at death, and Medicaid status. We also tested for interactions by race and cause of death for each outcome. SAS statistical software version 9.4 was used for all analyses (SAS Institute), and $P < .05$ was considered statistically significant. All tests were 2-tailed.

Results

We identified 1212 participants (630 men [52.0%]; 378 Black individuals [31.2%]; mean [SD] age at death, 81.0 [8.6] years) who constituted the study sample (**Table 1**). A total of 610 participants (50.3%) were married at the time of death, and 200 (16.5%) had less than a high school education. Decedents who died prior to 2013 were excluded owing to the unavailability of data on hospice use. Furthermore, decedents in REGARDS with no Medicare claims or who were enrolled only in Medicare part C were excluded. Among the 1358 REGARDS participants who died during the period from 2013 to 2015 with Medicare fee for service (parts A and B coverage) in the last 6 months of life, we further excluded 83 who had adjudicated sudden cause of death (eg, cardiac sudden deaths) and 54 who died owing to an accident, injury, suicide, or homicide. Among the remaining 1221 decedents, we excluded 9 with an undetermined cause of death and included 1212 with cause-of-death adjudication in the present analyses (eFigure in the Supplement).

As shown in Table 1, Black decedents were 2 years younger than White decedents at the time of death (mean [SD] age, 79.5 [9.2] vs 81.7 [8.1] years). Consistent with previously reported demographic differences for the REGARDS sample,[16] Black participants in this analysis were less educated than White participants (less than high school education, 108 of 378 [28.6%] vs 92 of 834 [11.0%]) and more likely to have Medicaid dual eligibility (156 of 378 [41.3%] vs 97 of 834 [11.6%]). Black decedents also had more comorbidities at the time of death than White decedents (mean [SD] Charlson Comorbidity Index sccore, 5.1 [3.1] vs 4.1 [3.0]). Cause of death was determined as dementia, CVD, or cancer for 220 of 378 Black decedents (58.2%) and 501 of 834 White decedents (60.1%). The remaining causes of death were grouped together as other illness.

Black decedents were less likely than White decedents to use hospice for 3 or more days (132 of 378 [34.9%] vs 385 of 834 [46.2%]; $P < .001$) (**Table 2**). Black decedents also had a higher number of repeated hospitalizations and ED visits in the last 6 months of life than White decedents; 224 of 378 Black decedents (59.3%) were seen in the ED more than once in the last 6 months of life vs 387 of 834 White decedents (46.4%). Of 378 Black decedents, 190 (50.3%) had more than 1 hospitalization in the last 6 months of life compared with 300 of 834 White decedents (36.0%). For intensive procedures, Black decedents generally were 2 or more times as likely as White decedents to have received each procedure in the last 6 months of life. For example, 80 of 378 Black decedents (21.2%) were intubated or had mechanical ventilation compared with 94 of 834 White decedents (11.3%).

After stratifying by cause of death, we found substantial racial differences in treatment intensity among those with CVD deaths (**Figure**). Although there were no significant differences in hospice use, Black participants who died of CVD were significantly more likely than White decedents to have more than 1 ED visit (68 of 102 [66.7%] vs 87 of 195 [44.6%]) and multiple hospital stays (53 of 102

[52.0%] vs 61 of 195 [31.3%]) and to have undergone intensive procedures (38 of 102 [37.3%] vs 34 of 195 [17.4%]). Similarly, among other deaths not attributed to cancer, dementia, or CVD, Black decedents were less likely to use hospice care (36 of 158 [22.8%] vs 120 of 333 [36.0%]) and significantly more likely than White decedents to have multiple ED visits (101 of 158 [63.9%] vs 154 of 333 [46.2%]) and multiple hospital stays (85 of 158 [53.8%] vs 129 of 333 [38.7%]) and to have undergone intensive procedures (70 of 158 [44.3%] vs 78 of 333 [23.4%]). Among cancer deaths, we did not observe statistically significant racial differences in treatment intensity among any indicators. Among participants whose cause of death was dementia, there was no significant difference in hospice use, ED visits, or hospitalizations by race, although Black decedents were significantly more likely to undergo intensive procedure use (6 of 37 [16.2%] vs 2 of 78 [2.6%]).

Our covariate-adjusted models are summarized in **Table 3**. Of primary interest is the association of race with outcomes after adjusting for covariates. Significant racial differences were found for all

Table 1. Demographic and Clinical Characteristics of REGARDS Decedents by Race

Variable	No. (%) Overall (N = 1212)	White (n = 834)	Black (n = 378)	*P* value
Age at REGARDS baseline, mean (SD), y	71.4 (8.5)	72.2 (8.2)	69.8 (9.1)	<.001
Age at death, mean (SD), y	81.0 (8.6)	81.7 (8.2)	79.5 (9.2)	<.001
Female sex	582 (48.0)	366 (43.9)	216 (57.1)	<.001
Educational level				
<High school	200 (16.5)	92 (11.0)	108 (28.6)	<.001
High school graduate	331 (27.3)	228 (27.3)	103 (27.3)	
Some college	323 (26.7)	227 (27.2)	96 (25.4)	
College graduate and above	358 (29.5)	287 (34.4)	71 (18.8)	
Income, $				
<20 000	247 (20.4)	117 (14.0)	130 (34.4)	<.001
20 000-34 000	357 (29.5)	247 (29.6)	110 (29.1)	
35 000-74 000	312 (25.7)	256 (30.7)	56 (14.8)	
≥75 000	113 (9.3)	96 (11.5)	17 (4.5)	
Refused	183 (15.1)	118 (14.2)	65 (17.2)	
Marital status				
Married	610 (50.3)	476 (57.1)	134 (35.5)	<.001
Single	44 (3.6)	20 (2.4)	24 (6.4)	
Widowed	408 (33.7)	263 (31.5)	145 (38.4)	
Divorced	134 (11.1)	73 (8.8)	61 (16.1)	
Other	16 (1.3)	2 (0.2)	14 (3.7)	
Has Medicaid	253 (20.9)	97 (11.6)	156 (41.3)	<.001
Charlson Comorbidity Index score, mean (SD)	4.4 (3.1)	4.1 (3.0)	5.1 (3.1)	<.001
Depression measured via CES-D score, mean (SD)	4.7 (4.7)	4.5 (4.6)	5.2 (5.0)	.02
Long-term care placement	289 (23.8)	176 (21.1)	113 (29.9)	<.001
Cause of death				
CVD	297 (24.5)	195 (23.4)	102 (27.0)	.16
Cancer	309 (25.5)	228 (27.3)	81 (21.4)	
Dementia	115 (9.5)	78 (9.4)	37 (9.8)	
Other illness	491 (40.5)	333 (39.9)	158 (41.8)	
Lives alone	429 (35.4)	282 (33.8)	147 (38.9)	.09
Available caregiver	971 (80.1)	680 (81.5)	291 (77.0)	.07
Stroke belt[a]	710 (58.6)	526 (63.1)	184 (48.7)	<.001
Census region				
Northeast	76 (6.3)	46 (5.5)	30 (7.9)	<.001
Midwest	188 (15.5)	105 (12.6)	83 (22.0)	
South	874 (72.1)	628 (75.3)	246 (65.1)	
West	74 (6.1)	55 (6.6)	19 (5.0)	

Abbreviations: CES-D, Center for Epidemiological Studies–Depression; CVD, cardiovascular disease; REGARDS, Reasons for Geographic and Racial Differences in Stroke.

[a] Residence in one of the following 8 states with high stroke mortality: North Carolina, South Carolina, Georgia, Tennessee, Alabama, Mississippi, Arkansas, or Louisiana.

4 outcomes (hospice use ≥3 days, multiple ED visits, multiple hospital stays, and intensive procedure use in the last 6 months of life). Black decedents were less likely than White decedents to use hospice (adjusted odds ratio [aOR], 0.72; 95% CI, 0.54-0.96) and more likely to use all other forms of health care in the last 6 months of life. In particular, Black decedents were more likely to have multiple ED visits (aOR, 1.35; 95% CI, 1.01-1.80) and hospitalizations (aOR, 1.39; 95% CI, 1.02-1.89) and had nearly twice the odds of undergoing intensive procedures in the last 6 months of life (aOR, 1.94; 95% CI, 1.40-2.70).

Cause of death was strongly associated with hospice use and treatment intensity in our fully adjusted model. For example, patients who died of CVD were twice as likely as those with cancer to have multiple hospital visits (aOR, 1.78; 95% CI, 1.20-2.64) or ED visits (aOR, 2.00; 95% CI, 1.38-2.88) and 3 times as likely to undergo intensive procedures (aOR, 2.92; 95% CI, 1.86-4.60) but less likely to use hospice at the end of life (aOR, 0.25; 95% CI, 0.18-0.36) (Table 3). On the other hand, while dementia was associated with less hospice use (aOR, 0.62; 95% CI, 0.38-1.01) and more ED visits (aOR, 2.29; 95% CI, 1.39-3.79), there was no significant increase in the use of intensive procedures relative to those with cancer (aOR, 1.12; 95% CI, 0.48-2.59).

Interactions by race and cause of death were not significant for hospice use, multiple hospital visits, or intensive procedure use. A statistically significant interaction was detected for multiple ED visits, which suggests an increased association among Black patients with CVD or other illness compared with cancer (eTable in the Supplement). Relative to those dying of cancer, Black decedents with CVD or other illnesses had a 2-fold odds of multiple ED visits relative to White decedents.

Discussion

Consistent with Brown et al,[28] we documented extensive racial differences in end-of-life treatment, with Black decedents receiving less hospice care and having more ED visits, hospitalizations, and intensive treatments in the 6 months immediately preceding death compared with White decedents. Although these findings remained even when we accounted for cause of death and other clinical and

Table 2. End-of-Life Health Care Use in the Last 6 Months of Life, Overall and by Race

Variable	No. (%)			P value
	Overall (N = 1212)	White (n = 834)	Black (n = 378)	
Hospice				
Any hospice use	643 (53.1)	479 (57.4)	164 (43.4)	<.001
Hospice use ≥3 d	517 (42.7)	385 (46.2)	132 (34.9)	<.001
Total No. of days in hospice, median (IQR)[a]	15.00 (5.00-59.00)	13.00 (5.00-59.00)	17.00 (5.00-58.50)	.35
Healthcare use				
ED visits	956 (78.9)	641 (76.9)	315 (83.3)	.01
≥2 ED visits	611 (50.4)	387 (46.4)	224 (59.3)	<.001
No. of ED visits, mean (SD)[a]	2.5 (1.7)	2.3 (1.6)	2.8 (1.8)	<.001
Hospital stays	894 (73.8)	593 (71.1)	301 (79.6)	.002
≥2 Hospital stays	490 (40.4)	300 (36.0)	190 (50.3)	<.001
No. of hospital stays, mean (SD)[a]	2.0 (1.2)	1.9 (1.1)	2.2 (1.3)	<.001
Intensive procedures				
Intubation or mechanical ventilation	174 (14.4)	94 (11.3)	80 (21.2)	<.001
Tracheostomy	17 (1.4)	5 (0.6)	12 (3.2)	<.001
Gastrostomy tube	51 (4.2)	22 (2.6)	29 (7.7)	<.001
Hemodialysis	70 (5.8)	27 (3.2)	43 (11.4)	<.001
Enteral or parenteral nutrition	60 (5.0)	29 (3.5)	31 (8.2)	<.001
CPR	53 (4.4)	22 (2.6)	31 (8.2)	<.001
Any intensive procedures	279 (23.0)	148 (17.8)	131 (34.7)	<.001

Abbreviations: CPR, cardiopulmonary resuscitation; ED, emergency department; IQR, interquartile range.

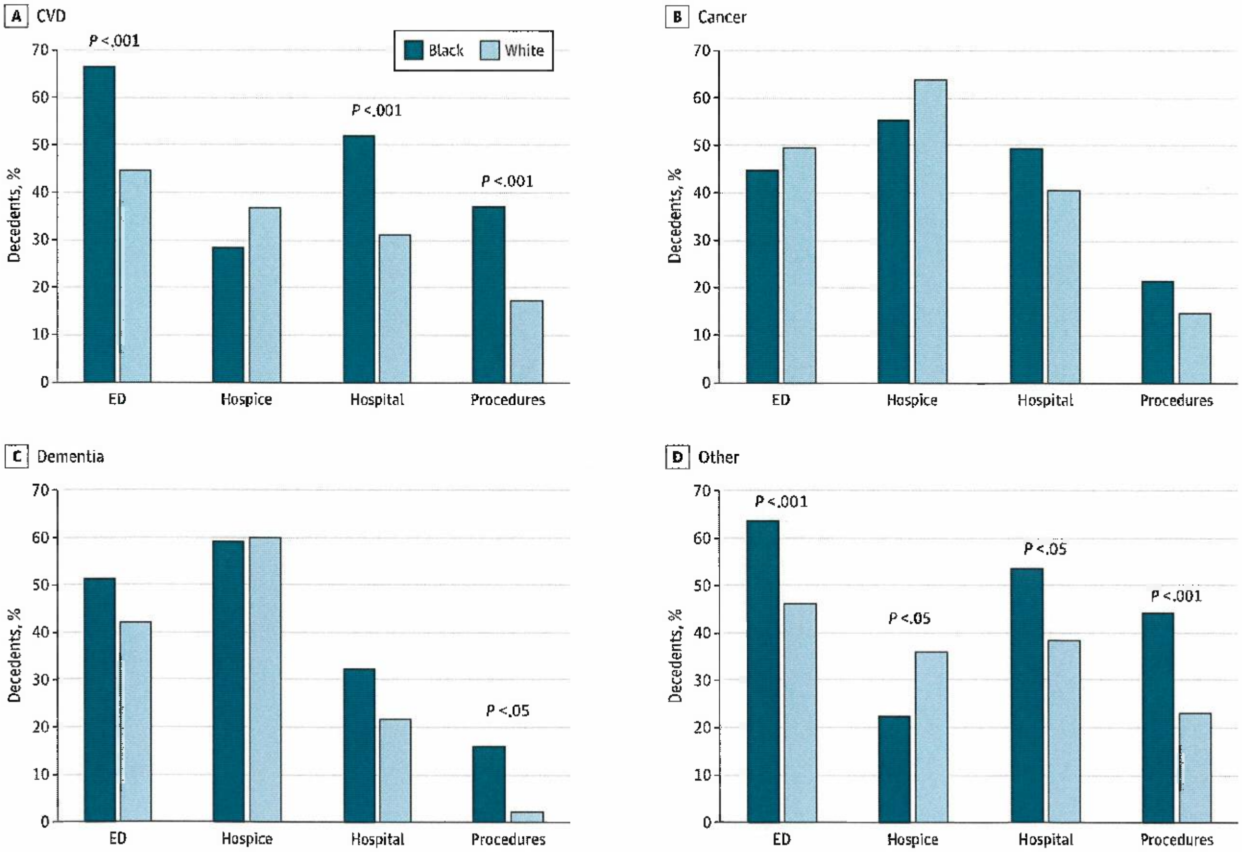
[a] Among those with any ED visits or hospital stays.

demographic characteristics in the analysis, we found that racial differences in treatment intensity were especially pronounced among those with noncancer diagnoses.

Although this study was not able to assess whether treatment-intensity measures were aligned with patient and family care treatment preferences, we know that most individuals report that they want less invasive care at the end of life.[2,29] Several possible explanations may underlie the higher intensity of care received by Black decedents in our study. First, other studies have documented that lack of trust in the medical system by Black patients is associated with a reduced willingness to forgo life-sustaining measures[30,31] and an increased use of the ED for usual care.[32] Second, poor communications between Black patients and health care professionals are documented and may be associated with differences in the intensity of health care service use.[33,34] In addition, cultural and spiritual differences may play an important in role in choosing to forgo life-sustaining procedures.[35] Black decedents may also have less access to higher-quality end-of-life care, including engagement in advance care planning in part owing to lower health literacy.[36]

Our study afforded us the opportunity to examine racial differences in the context of rigorously ascertained causes of death. Consistent with other findings,[37] underlying cause of death was strongly associated with hospice use after controlling for other factors. Persons without cancer were far less likely to use hospice care relative to individuals with a cancer-related cause of death. Several possible explanations exist for the observed discrepancy in hospice use based on underlying cause of death. Health care professionals who provide care for many common noncancer illnesses may lack awareness about the utility of hospice services. Low use of hospice care by patients without cancer may also be associated with poor prognostic accuracy for many common noncancer illnesses, such as CVD or dementia. Cancer trajectories are more predictable than noncancer disease trajectories.[38]

Figure. End-of-Life Health Care Use in the Last 6 Months of Life by Race and Cause of Death



CVD indicates cardiovascular disease; ED, emergency department.

Thus, it is easier for physicians to prognosticate when the life expectancy of a patient with cancer is 6 months or less, a criterion for hospice enrollment under the Medicare Hospice Benefit. Among cancer deaths, in fact, we did not find any racial differences in any marker of treatment intensity we examined, which suggests that the use of hospice care and more supportive care services may be more widely disseminated among those with advanced cancer, possibly reflecting the increased emphasis on end-of-life care for patients with cancer in the US health care system in recent years. Among decedents with dementia, we did not find any differences in hospice use, but we still saw a significant increase in the use of life-sustaining procedures among Black patients, a particularly troublesome finding given the lack of utility of these procedures at the end of life for this population.[39,40]

Despite an increased use of hospice care in the United States, there is a continued use of high-intensity treatments at the end of life,[41] and significant differences by race and cause of death remain.[3] Efforts to reduce disparities in the quality of end-of-life care must be prioritized. In particular, targeted efforts to increase advance care planning among Black and other racial minority populations should be expanded.[42] The recent Centers for Medicare & Medicaid Services regulation to reimburse physicians and others for advance care planning discussions is another important step toward that goal.[43] Reducing the stigma of hospice use through education and community outreach is critical.[44,45] In particular, reducing disparities in hospice use in populations with noncancer causes of death will require improved prognostication, better patient-clinician communication, and rethinking current hospice outreach and enrollment practices.[46,47]

Using this national study with oversampling of Black participants, we had a large population to examine racial differences in end-of-life care. Furthermore, we had expert adjudication of the underlying cause of death and, hence, could examine differences in hospice use and other treatments by cause of death. We also included a marker of income. Disproportionate socioeconomic

Table 3. Association of Race With Hospice Use, Multiple ED Visits, Multiple Hospitalizations, and Intensive Procedure Use in the Last 6 Months of Life

	Odds ratio (95% CI)[a]							
	Hospice use ≥3 d		≥2 ED visits		≥2 Hospital visits		Any intensive procedures	
Variable	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2
Race, Black vs White	0.63 (0.49-0.81)	0.72 (0.54-0.96)	1.68 (1.31-2.15)	1.35 (1.01-1.80)	1.80 (1.41-2.30)	1.39 (1.02-1.89)	2.46 (1.87-3.24)	1.94 (1.40-2.70)
Cause of death[b]								
CVD	NA	0.25 (0.18-0.36)	NA	2.00 (1.38-2.88)	NA	1.78 (1.20-2.64)	NA	2.92 (1.86-4.60)
Dementia	NA	0.62 (0.38-1.01)	NA	2.29 (1.39-3.79)	NA	1.74 (0.98-3.08)	NA	1.12 (0.48-2.59)
Other illness	NA	0.23 (0.17-0.32)	NA	2.00 (1.44-2.78)	NA	2.33 (1.63-3.35)	NA	3.97 (2.64-5.98)
Female sex	NA	1.25 (0.95-1.65)	NA	1.19 (0.90-1.58)	NA	1.61 (1.18-2.18)	NA	1.16 (0.83-1.62)
Age at death	NA	1.03 (1.02-1.05)	NA	1.01 (1.00-1.03)	NA	1.00 (0.99-1.02)	NA	0.95 (0.93-0.97)
Educational level, ≥college vs ≤ college	NA	0.96 (0.73-1.27)	NA	0.80 (0.60-1.05)	NA	0.92 (0.68,1.26)	NA	0.91 (0.64-1.29)
Marital status: married vs other	NA	1.21 (0.91-1.61)	NA	1.06 (0.79-1.41)	NA	1.17 (0.85-1.60)	NA	1.16 (0.82-1.64)
Income, $								
≥75 000 vs <75 000	NA	1.06 (0.69-1.65)	NA	1.24 (0.79-1.94)	NA	0.90 (0.55-1.46)	NA	0.83 (0.48-1.43)
Refused vs <75 000	NA	0.75 (0.53-1.07)	NA	0.80 (0.56-1.13)	NA	0.73 (0.50-1.08)	NA	0.92 (0.60-1.40)
Dual eligible for Medicare and Medicaid	NA	1.12 (0.80-1.56)	NA	0.91 (0.65-1.27)	NA	0.77 (0.54-1.11)	NA	0.81 (0.54-1.20)
Charlson Comorbidity Index score	NA	0.94 (0.90-0.99)	NA	1.33 (1.27-1.40)	NA	1.50 (1.42-1.59)	NA	1.21 (1.15-1.28)

Abbreviations: CVD, cardiovascular disease; ED, emergency department; NA, not applicable.

[a] Model 1, unadjusted; model 2, adjusted for all variables listed.

[b] Referent group is cancer.

disadvantage is associated with some, but not all, of the differences in health care intensity at the end of life by race.[28] Although our study was able to detect differences by race, larger studies are required to better examine interactions by race, educational level, and cause of death to understand the mechanisms by which disparities may exist.

Limitations

Our findings should be interpreted with a number of potential limitations in mind. We were limited to decedents with Medicare (in particular, those who had fee-for-service Medicare 6 months before death). Those excluded were younger, more likely to be Black, and had lower income. Our results therefore may not be generalizable to all decedents. Although we were able to identify deaths due to cancer, CVD, and dementia, our dementia decedent subgroup was too small to capture meaningful differences. This group in particular requires further study given the growing prevalence of persons living with dementia and the need for better treatment at the end of life, including appropriate hospice care use. Dementia may also have been underdiagnosed in our sample of patients who did not have routine cognitive testing,[48] with differential diagnosis by race. In addition, we grouped together multiple causes of death as "other illness." Although we examined differences between Black and White decedents, we were unable to examine other racial groups that were excluded by design in REGARDS. Our work regarding differences in care may still be applicable to other disadvantaged populations. Furthermore, while we included careful adjustment of variables in models, there may still be residual confounding. Finally, we did not have detailed information on patient and family treatment preferences, whether treatment was concordant with care received, prognostic uncertainty, or overall satisfaction with the care received. These factors are likely to vary by disease status and should be explored further.

Conclusions

Our work suggests that Black decedents undergo more intensive treatments at the end of life and are less likely to use hospice services relative to White decedents. More sustained efforts must be made to reduce disparities in end-of-life care through efforts to better educate and train health care professionals and to promote the discussion of personal values and treatment preferences for the end of life in Black populations.

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SUPPLEMENT.

eFigure. Derivation of Analytic Sample

eTable. Interaction of Race and Cause of Death on End-of-Life Treatment Intensity

Newsroom

Study Documents Racial Differences in U.S. Hospice Use and End-of-Life Care Preferences

10/28/2020

Black Americans pursue more intensive treatments than white Americans in the last six months of life; white people are more likely to use hospice care

Credit: Getty Images

In a new medical records analysis of racial disparities in end-of-life care, researchers at Johns Hopkins Medicine and three collaborating institutions report that Black patients voluntarily seek substantially more intensive treatment, such as mechanical ventilation, gastronomy tube insertion, hemodialysis, CPR and multiple emergency room visits in the last six months of life, while white patients more often choose hospice services.

This finding, researchers say, demonstrates the extent of different choices that are made in seeking end-of-life care despite an overall increase nationwide in the U.S. toward the use of hospice care regardless of diagnosis, especially in noncancer deaths.

“What’s unique about our study is that we show this disparity is persistent — not decreasing over time — and appears to be fairly general because it is not specific to a few diseases such as cancer,” says David L. Roth, Ph.D., director of the Johns Hopkins Center on Aging and Health (COAH) and a co-author of the study. These persistent disparities may impact the quality of end-of-life experiences differently for Black and white Americans and underline the importance of advance care planning and advance directives — things that other studies have shown are less likely to be in place for Black Americans.

In a report on the study published online Aug. 24 in the *Journal of the American Medical Association Network Open*, the investigators note that the increasing use of hospice services in the last six months of life is seen as a positive trend — reducing emergency department visits, repeated hospital stays, and intensive, invasive life-preserving procedures such as intubation/mechanical ventilation, tracheostomies and feeding tubes. For the study, researchers analyzed data from the ongoing, population-based REasons for Geographical and Racial Differences in Stroke (REGARDS) study coordinated by the University of Alabama at Birmingham and funded by the National Institutes of Health. Between 2003 and 2007, REGARDS enrolled more than 30,000 participants in the United States, ages 45 or older, to better understand why Southerners and Black Americans have higher rates of stroke, and related diseases that affect brain health, than other Americans. By design, REGARDS has an oversampling of Black Americans and residents of the “stroke belt” in the Southeastern United States (including Alabama, Arkansas, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina and Tennessee), to gain more information about the racial and geographical health disparities and mortality rate differences that exist.

For the current study, Roth and his colleagues identified REGARDS participants who defined themselves as either Black or white Americans, who died between 2013 and 2015 due to natural causes (excluding sudden death), and whose records were linked to Medicare claims. They examined patients who received hospice care for three or more days in the last six months of life, and if these people had multiple hospitalizations, made any emergency department visits, or were given intensive medical procedures during the same time period.

Ultimately, their study population contained 1,212 participants (31.2% Black and 48% female, with a mean age of 81).

The researchers found that 34.9% of Black study participants who died used hospice services over the study period, compared with 46.2% of white participants. Black Americans were significantly less likely than white Americans to use three or more days of hospice. Also, Black Americans were more likely to have multiple emergency room visits and hospitalizations, or to undergo intensive treatments in the last six months of life — regardless of the cause of death. This was especially true for noncancer deaths.

“Despite tremendous growth in palliative care and hospice use in the United States, our work highlights a pressing need to address racial disparities in end-of-life care,” says study lead author Katherine Ornstein, Ph.D., M.P.H., director of research for the Institute of Care Innovations at Home at Mount Sinai and associate professor of geriatrics and palliative medicine at Mt. Sinai’s Icahn School of Medicine in New York.

The study team recommends that more sustained efforts be made to reduce disparities in end-of-life-care through efforts to better educate and train health care providers and to promote the discussion of personal values and treatment preferences for the end of life in Black populations.

In addition to evidence that has shown that hospice care is more medically beneficial to patients in the end of life, hospice care, the researchers say, may also cost less than emergency or invasive treatments at the end stages of a person’s life. A 2013 study found $2,561 in savings to Medicare for each patient enrolled in hospice 53–105 days before death, compared with a matched, nonhospice control. Even higher savings were seen 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.

Along with Roth and Ornstein, the study team included COAH’s Jin Huang, Ph.D., and Orla Sheehan, M.D., Ph.D., as well as Johns Hopkins Bloomberg School of Public Health associate Chanee Fabius, Ph.D. Additional researchers included Emily Levitan, Sc.D., and J. David Rhodes, M.P.H., from the University of Alabama at Birmingham, and Monika Safford, M.D., from Weill Cornell Medicine.

This research project is supported by cooperative agreement U01 NS041588 from the National Institute of Neurological Disorders and Stroke and the National Institute on Aging. Additional funding was provided by R01 HL80477 from the National Heart, Lung, and Blood Institute.

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Racial and Ethnic Differences in Hospice Use and Hospitalizations at End-of-Life Among Medicare Beneficiaries With Dementia

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Key Points

Question

How does use of hospice and hospital services at the end of life differ by race and ethnicity among patients with dementia?

Findings

This cohort study found that non-Hispanic Black and Hispanic decedents with dementia used less hospice but more emergency department and inpatient services, and incurred roughly 60% higher Medicare inpatient expenditures at the end of life, compared with non-Hispanic White decedents. The proportion of dementia beneficiaries completing advance care planning was significantly lower among non-Hispanic Black and Hispanic decedents compared with non-Hispanic White decedents.

Meaning

These results highlight the importance of understanding how end-of-life care utilization and treatment preferences among patients with dementia differ across racial and ethnic groups.

Abstract

Importance

The pool of studies examining ethnic and racial differences in hospice use and end-of-life hospitalizations among patients with dementia is limited and results are conflicting, making it difficult to assess health care needs of underresourced racial and ethnic groups.

Objective

To explore differences in end-of-life utilization of hospice and hospital services among patients with dementia by race and ethnicity.

Design, Setting, and Participants

This cohort study used national survey data from the Health and Retirement Study linked with Medicare and Medicaid claims that reflected a range of socioeconomic, health, and psychosocial characteristics. Eligible participants were Medicare fee-for-service beneficiaries aged 65 years or older diagnosed with dementia who died between 2000 and 2016. Analyses were performed from June to December 2021.

Exposures

Race and ethnicity.

Main Outcomes and Measures

We examined the frequency and costs of hospice care, emergency department (ED) visits, and hospitalizations during the last 180 days of life among Medicare decedents with dementia. We analyzed the proportion of dementia decedents with advance care planning and their end-of-life care preferences.

Results

The cohort sample included 5058 beneficiaries with dementia (mean [SD] age, 85.5 [8.0] years; 3038 women [60.1%]; 809 [16.0%] non-Hispanic Black, 357 [7.1%] Hispanic, and 3892 non-Hispanic White respondents [76.9%]). In adjusted analysis, non-Hispanic Black decedents (odds ratio [OR], 0.65; 95% CI, 0.55-0.78), nursing home residents (OR, 0.81; 95% CI, 0.71-0.93), and survey respondents represented by a proxy (OR, 0.84; 95% CI, 0.71-0.99) were less likely to use hospice, whereas older decedents (age 75-84 vs 65-74 years: OR, 1.39; 95% CI, 1.12-1.72; age ≥85 vs 65-74 years: OR, 1.39; 95% CI, 1.13-1.71), women (OR, 1.19; 95% CI, 1.05-1.35), and decedents with higher education (high school vs less than high school: OR, 1.17; 95% CI, 1.01-1.36; more than high school vs less than high school: OR, 1.32; 95% CI, 1.13-1.54), more severe cognitive impairment (OR, 1.51; 95% CI, 1.02-2.23), and more instrumental activities of daily living limitations

(OR, 1.07; 95% CI, 1.01-1.12) were associated with higher hospice enrollment. A higher proportion of Black and Hispanic decedents with dementia used ED (645 of 809 [79.7%] and 274 of 357 [76.8%] vs 2753 of 3892 [70.7%]; $P < .001$) and inpatient services (625 of 809 [77.3%] and 275 of 357 [77.0%] vs 2630 of 3892 [67.5%]; $P < .001$) and incurred roughly 60% higher inpatient expenditures at the end of life compared with White decedents (estimated mean: Black, $23 279; 95% CI, $20 690-$25 868; Hispanic, $23 471; 95% CI, $19 532-$27 410 vs White, $14 609; 95% CI, $13 800-$15 418). A higher proportion of Black and Hispanic than White beneficiaries with dementia who were enrolled in hospice were subsequently admitted to the ED (56 of 309 [18.1%] and 22 of 153 [14.4%] vs 191 of 1967 [9.7%]; $P < .001$) or hospital (48 of 309 [15.5%] and 17 of 153 [11.1%] vs 119 of 1967 [6.0%]; $P < .001$) before death. The proportion of dementia beneficiaries completing advance care planning was lower among Black (146 of 704 [20.7%]) and Hispanic (66 of 308 [21.4%]) beneficiaries compared with White beneficiaries (1871 of 3274 [57.1%]). A higher proportion of Black and Hispanic decedents with dementia had written instructions choosing all care possible to prolong life (30 of 144 [20.8%] and 12 of 65 [18.4%] vs 72 of 1852 [3.9%]), whereas a higher proportion of White decedents preferred to limit care in certain situations (1708 of 1840 [92.8%] vs 114 of 141 [80.9%] and 51 of 64 [79.7%]), withhold treatments (1448 of 1799 [80.5%] vs 87 of 140 [62.1%] and 41 of 62 [66.1%]), and forgo extensive life-prolonging measures (1712 of 1838 [93.1%] vs 120 of 138 [87.0%] and 54 of 65 [83.1%]).

Conclusions and Relevance

The results of this cohort study highlight unique end-of-life care utilization and treatment preferences across racial and ethnic groups among patients with dementia. Medicare should consider alternative payment models to promote culturally competent end-of-life care and reduce low-value interventions and costs among the population with dementia.

Introduction

Despite advances in dementia prevention and treatment,[1] end-of-life care remains critically important for all individuals living with the condition. Hospice, for example, provides comfort care and support for terminal patients and their families. Older adults with dementia are among those who are most likely to benefit from end-of-life hospice care because these individuals often experience multiple distressing symptoms (eg, pain, depression, and delusions) and poor quality of life.[2] To qualify for the Medicare hospice benefit, a patient must be certified by 2 physicians as terminally ill, defined as having a medical prognosis of 6 months or less.[3] However, prognostic challenges in dementia, such as its long disease duration and unpredictable trajectories, make certifying eligibility for the Medicare hospice benefit difficult. Although hospice utilization in the Medicare population has increased in recent decades, the service remains underused, with only half of Medicare decedents enrolling in the hospice benefit.[3,4,5] Individuals with noncancer illness, including those with dementia, and from underserved communities have lower hospice utilization rates.[5,6,7,8]

Some evidence suggests that, among individuals with dementia, non-Hispanic Black individuals experience more aggressive end-of-life care (eg, artificial nutrition, mechanical ventilation, and intensive care unit admissions) compared with non-Hispanic White individuals.[9,10,11] However, the pool of studies examining racial and ethnic differences in hospice use and end-of-life hospitalizations among patients with dementia is limited and the results conflicting.[9] For example, one analysis of nursing home residents with advanced dementia in Boston found that Black individuals were more likely than White to receive hospice referrals,[12] whereas a US national study suggested that hospice use was lower among Black residents.[13] The type and intensity of care individuals receive at the end of life may differ for those with more advanced dementia,[10] but claims-based analyses lack sufficient clinical detail to characterize cognitive function. Furthermore, while studies have examined dementia end-of-life care, the analyses often are restricted to nursing home residents.[14,15,16] These estimates are limited because they omit a substantial proportion of dementia patients living at home or other settings prior to death.[6] The samples typically lack racial and ethnic diversity, and thus robust data on non-White decedents with dementia are sparse.[9] For example, prior examinations of hospice use have compared differences between Black and White patients with dementia but lacked data on other racial or ethnic groups.[14,17,18] The limitations of previous analyses, such as a lack of dementia severity measures and use of unrepresentative samples, make it difficult to assess unique end-of-life care needs for underresourced racial and ethnic groups.

This study examined the frequency and costs of end-of-life hospice care, emergency department (ED) visits, and hospitalizations among Medicare decedents with dementia. Our study extends existing research by analyzing how dementia end-of-life care utilization patterns differ by race and ethnicity. We supplemented claims data with national survey data that included measures of cognitive function and socioeconomic factors known to affect end-of-life care. We also analyzed ethnic and racial differences in patient instructions regarding end-of-life treatment based on survey data. Our sample included community-dwelling patients and nursing home residents, thus making our findings more representative of the general dementia population. We hypothesized that non-Hispanic Black and Hispanic patients with dementia had lower hospice use but more ED and hospital admissions at the end of life compared with non-Hispanic White patients.

Methods

The Tufts Medical Center/Tufts University Health Sciences institutional review board approved this cohort study via expedited review procedures per 45 CFR 46.110(b)(4); informed consent was not required because the study analyzed existing, secondary data. We followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.

Data and Sample

We used data from the 2000-2016 Health and Retirement Study (HRS) linked with Medicare and Medicaid claims. The HRS is a nationally representative biennial survey of US adults aged 50 or older, collecting a range of respondent socioeconomic, health, and psychosocial characteristics.[19] Each wave of HRS interviews roughly 20 000 respondents, with response rates ranging from 81% to 89%.[20] The HRS oversamples Black and Hispanic households, making it well suited for our investigation of racial and ethnic disparities. We used HRS survey data linked to respondents' Medicare fee-for-service part A (ie, inpatient, skilled nursing facility, hospice, and home health), part B (ie, physician visit, outpatient care, and durable medical equipment), and part D (ie, prescription drug) claims, as well as Medicaid analytic extracts and summary files for dually eligible beneficiaries. These health insurance claims included diagnosis codes, medical and prescription drug utilization, date of service, and reimbursement for all services rendered.

Our sample included HRS respondents aged 65 years and older diagnosed with dementia who died between 2000 and 2016 (eFigure in the Supplement). We identified individuals with a claims-based diagnosis of dementia during the study period by using *International Classification of Diseases, Ninth* or *Tenth Revisions* diagnosis codes.[21,22] We required all patients to have continuous enrollment in Medicare fee-for-service for at least 6 months prior to death.

Outcome Measures

Hospice We used HRS-linked Medicare claims to analyze the proportion of dementia decedents enrolling in hospice during the last 180 days of life and their cumulative hospice days and hospice expenditures paid by Medicare. We also examined late hospice enrollment (within 7 and 3 days before death) as an indicator of poor end-of-life care quality.

ED Visits and Hospitalizations We examined the average number of outpatient ED visits, inpatient ED visits, and hospital stays during the last 180 days of life, as well as Medicare expenditures for these visits. We calculated total expenditures for inpatient ED and hospital admissions combined because those payments cannot be separately identified in Medicare claims.

We identified major causes of hospitalizations based on principal discharge diagnoses, using the Agency for Healthcare Research and Quality (AHRQ) Clinical Classifications Software (CCS) and Clinical Classifications Software Refined (CCSR) tools.[12,23] Additionally, we examined the proportion of potentially avoidable hospitalizations for ambulatory care sensitive chronic conditions (ie, hypertension, diabetes, asthma, chronic obstructive pulmonary disease, and heart failure) and acute infections (ie, bacterial pneumonia and urinary tract infection), as defined by the AHRQ Prevention Quality Indicators, version 2021.[24]

End-of-Life Care Preferences We examined patient end-of-life care preferences using the HRS exit interview data reported by a proxy within 2 years after the study participant's death.[25] The interview asked whether the participant had advance care planning, ie, written instructions specifying the treatment or care they wanted to receive during the final days of life. Of those study participants with advance care planning, the interview asked whether these instructions expressed any desire to: (1) receive all care possible to prolong life; (2) limit care in certain situations; (3) have any treatment withheld; or (4) keep them comfortable and pain free but forego extensive measures to prolong life (choices not mutually exclusive; each categorized as yes or no).

Statistical Analysis

We developed 2-part models to assess whether Medicare expenditures for hospice, outpatient ED, and inpatient services differed by race and ethnicity, categorized as non-Hispanic White, non-Hispanic Black, and Hispanic. The first part used a logistic regression to estimate the probability of any use; the second part used a generalized linear model (GLM) with log link and γ distribution to estimate mean expenditures among users. Combining results from these 2 model components yielded population expenditure estimates. We standardized all Medicare expenditures to 2016 US$.

Covariates in both logistic regression and GLM included age, sex, education, cognition, functional limitations, comorbidities, Medicare-Medicaid dual eligibility, nursing home status, and proxy respondent. We measured cognition using HRS-imputed Telephone Interview for Cognitive Status (TICS) scores for self-respondents and Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) scores for those study participants represented by a proxy. We quantified functional status in terms of the number of limitations in activities of daily living (ADL; including getting dressed, walking across the room, bathing, eating, getting in and out of bed, and using the toilet) and instrumental ADL (IADL; including preparing meals, shopping for groceries, using the telephone, taking medication, and managing one's money). For end-of-life care preferences, we analyzed the proportion of beneficiaries with advance care planning and their specific instructions (as detailed in "Outcome measures") by race and ethnicity. All analyses were performed from June to December 2021.

Results

Sample Characteristics

Our study sample included 5058 beneficiaries with dementia; 3892 beneficiaries (76.9%) were non-Hispanic White, 809 (16.0%) were non-Hispanic Black, and 357 (7.1%) were Hispanic. Overall, the mean (SD) age of beneficiaries was 85.5 (8.0) years and 3038 participants were women (60.1%) (Table 1). Compared with Black and Hispanic decedents, White decedents with dementia were older (mean age [SD]: 85.9 [7.7] years vs Black, 84.0 [8.8] years and Hispanic, 84.0 [8.6] years; *P* < .001), had higher education levels (1234 of 3892 [31.7%] completed more than high school vs 117 of 809 Black decedents [14.5%] and 40 of 357 Hispanic decedents [11.2%]; *P* < .001), better cognitive scores (mean [SD] TICS scores: 15.9 [6.2] vs Black, 12.5 [6.0] and Hispanic, 13.6 [5.3]; mean [SD] IQCODE scores: 4.1 [0.8] vs 3.9 [0.8] and 4.0 [0.8]; *P* < .001), and fewer functional limitations (eg, mean [SD] IADL limitations: 2.1 [1.8] vs Black, 2.2 [1.9] and Hispanic, 2.3 [1.9]; *P* = .006), were more likely to live in a nursing home (1805 of 3666 [49.2%] vs 336 of 766 Black decedents [43.9%] and 127 of 341 Hispanic decedents [37.2%]; *P* < .001) and less likely to be dually eligible for Medicare and Medicaid (741 of 3892 [19.0%] vs 286 of 809 Black decedents [35.4%] and 169 of 357 Hispanic decedents [47.3%]; *P* < .001).

Table 1.

Sample Characteristics

Characteristic	Respondents, No. (%)				*P* value
	Total (n = 5058)	**Non-Hispanic White (n = 3892)**	**Non-Hispanic Black (n = 809)**	**Hispanic (n = 357)**	
Age, mean (SD), y	85.5 (8.0)	85.9 (7.7)	84.0 (8.8)	84.0 (8.6)	<.001
Age category, y					
65-74	587 (11.6)	381 (9.8)	148 (18.3)	58 (16.3)	<.001
75-84	1667 (33.0)	1256 (32.3)	279 (34.5)	132 (37.0)	
≥85	2804 (55.4)	2255 (57.9)	382 (47.2)	167 (46.8)	
Sex					
Women	3038 (60.1)	2325 (59.7)	509 (62.9)	204 (57.1)	.12
Men	2020 (39.9)	1567 (40.3)	300 (37.1)	153 (42.9)	
Education					
<High school	2124 (42.0)	1322 (34.0)	527 (65.1)	275 (77.0)	<.001
High school	1543 (30.5)	1336 (34.3)	165 (20.4)	42 (11.8)	
>High school	1391 (27.5)	1234 (31.7)	117 (14.5)	40 (11.2)	
Medicare-Medicaid dual eligibility	1196 (23.7)	741 (19.0)	286 (35.4)	169 (47.3)	<.001
Nursing home resident	2268 (47.5)	1805 (49.2)	336 (43.9)	127 (37.2)	<.001
Proxy respondent	2013 (42.4)	1494 (40.9)	350 (46.1)	169 (49.6)	<.001
TICS scores, mean (SD)[a]	15.3 (6.2)	15.9 (6.2)	12.5 (6.0)	13.6 (5.3)	<.001
IQCODE scores, mean (SD)[a]	4.1 (0.8)	4.1 (0.8)	3.9 (0.8)	4.0 (0.8)	<.001
ADL limitations, mean (SD)	2.1 (2.1)	2.1 (2.1)	2.1 (2.1)	2.4 (2.2)	.04
IADL limitations, mean (SD)	2.1 (1.8)	2.1 (1.8)	2.2 (1.9)	2.3 (1.9)	.006
Comorbidities, mean (SD)[b]	3.3 (1.6)	3.3 (1.6)	3.4 (1.5)	3.4 (1.6)	.17

Abbreviations: ADL, activities of daily living; IADL, instrumental activities of daily living; IQCODE, Informant Questionnaire on Cognitive Decline in the Elderly; TICS, Telephone Interview for Cognitive Status.

[a] TICS scores were available for self-respondents (2702 respondents) and IQCODE scores were available for those represented by a proxy (1763 respondents).

[b] Comorbidity count ranged from 0 to 8, including high blood pressure, diabetes, cancer, lung disease, heart disease, stroke, psychiatric problems, and arthritis, based on HRS survey data.

Hospice Care by Race and Ethnicity

Less than half of the decedents with dementia in our sample (2429 of 5058 [48.0%]) used hospice care in their last 180 days of life (Table 2). The proportion was lower among Black and Hispanic compared with White decedents (309 of 809 [38.2%] and 153 of 357 [42.9%] vs 1967 of 3892 [50.5%], *P* < .001). In adjusted analysis, Black decedents (odds ratio [OR]: 0.65; 95% CI, 0.55-0.78), nursing home residents (OR, 0.81; 95% CI, 0.71-0.93), and respondents represented by a proxy were less likely to use hospice (OR, 0.84; 95% CI, 0.71-0.99), whereas older age (75-84 vs 65-74 years: OR, 1.39; 95% CI, 1.12-1.72; ≥85 vs 65-74 years: OR, 1.39; 95% CI, 1.13-1.71), women (OR, 1.19; 95% CI, 1.05-1.35), higher education (high school vs less than high school: OR, 1.17; 95% CI, 1.01-1.36; more than high school vs less than high school: OR, 1.32; 95% CI, 1.13-1.54), more severe cognitive impairment (OR, 1.51; 95% CI, 1.02-2.23), and more IADL limitations (OR, 1.07; 95% CI, 1.01-1.12) were associated with higher hospice enrollment (eTable 1 in the Supplement).

Table 2.

Unadjusted Hospice Use, Emergency Department Visits, and Hospitalizations in the Last 180 Days of Life and End-of-Life Care Preferences Among Dementia Decedents by Race and Ethnicity

End-of-life service	Respondents, No. (%)				*P* value
	All (N = 5058)	Non-Hispanic White (n = 3892)	Non-Hispanic Black (n = 809)	Hispanic (n = 357)	
Hospice care					
Any hospice enrollment	2429 (48.0)	1967 (50.5)	309 (38.2)	153 (42.9)	<.001
Total hospice days, mean (SD), d[a]	49.9 (61.3)	50.4 (61.8)	50.1 (59.9)	43.5 (57.4)	.41
Hospice enrollment only during the last 7 d of life[a]	735 (30.3)	606 (30.8)	84 (27.2)	45 (29.4)	.42
Hospice enrollment only during the last 3 d of life[a]	334 (13.8)	269 (13.7)	43 (13.9)	22 (14.4)	.97
ED visits					
Any visit after hospice enrollment	269 (11.1)	191 (9.7)	56 (18.1)	22 (14.4)	<.001
Any visit	3672 (72.6)	2753 (70.7)	645 (79.7)	274 (76.8)	<.001
Total No. of outpatient visits, mean (SD)[a]	2.5 (2.1)	2.5 (2.0)	2.8 (2.2)	2.4 (2.1)	.06
Total No. of inpatient visits, mean (SD)[a]	1.8 (1.2)	1.7 (1.1)	2.2 (1.4)	1.9 (1.1)	<.001
Hospitalization					
Any hospitalization after hospice enrollment	184 (7.6)	119 (6.1)	48 (15.5)	17 (11.1)	<.001
Any hospitalization	3530 (69.8)	2630 (67.6)	625 (77.3)	275 (77.0)	<.001
Total No. of hospitalizations, mean (SD)[a]	2.1 (1.4)	2.0 (1.3)	2.4 (1.5)	2.3 (1.5)	<.001
Length of stay, mean (SD), d[a]	8.5 (7.0)	8.0 (6.6)	10.0 (8.5)	9.6 (6.6)	<.001
Advance care planning (4286 respondents)	2083 (48.6)	1871 (57.2)	146 (20.7)	66 (21.4)	NA

Abbreviation: ED, emergency department.

These are unadjusted, descriptive statistics. *P* values were based on χ^2 tests (categorical variables) and ANOVA tests (continuous variables).

[a] Among users.

Among hospice users, the mean (SD) length of stay was 1.6 (2.0) months, and Hispanic decedents with dementia had the shortest stays (mean [SD] stay: White, 50.4 [61.8] days; Black, 50.1 [59.9] days; Hispanic, 43.5 [57.4] days; *P* = .41) (Figure 1). Late hospice enrollment was common across all racial and ethnic groups; overall, 735 of 2429 beneficiaries with dementia (30.3%) entered only during the last 7 days of life, and 334 of 2429 (13.8%) only during the last 3 days of life. Model estimated mean Medicare hospice expenditures did not differ significantly by race or ethnicity: $4097 (95% CI, $3835-$4360) per dementia decedent among White beneficiaries, $3417 (95% CI, $2858-$3976) among Black beneficiaries, and $3372 (95% CI, $2605-$4140) among Hispanic beneficiaries (Figure 2).

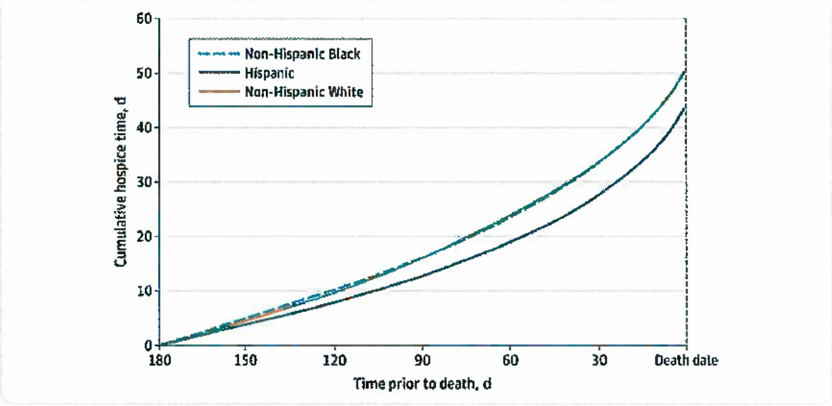

Figure 1.

Cumulative Hospice Days in the Last 180 Days of Life Among Dementia Beneficiaries Enrolling in Hospice Care, by Race and Ethnicity

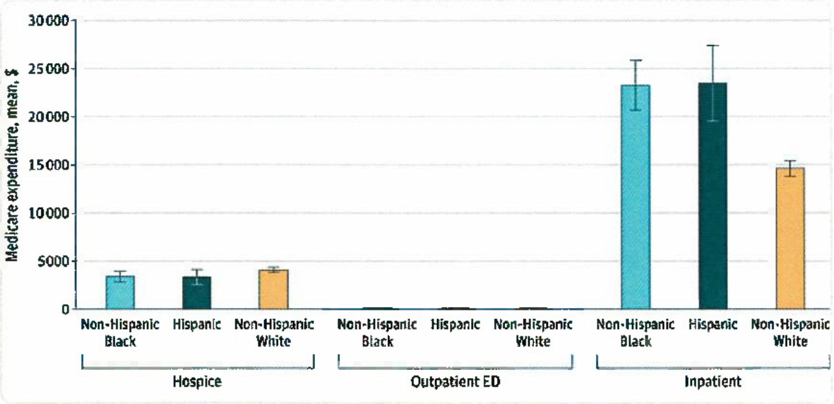

Figure 2.

Estimated Mean Medicare Expenditures per Dementia Decedent in the Last 180 Days of Life

ED indicates emergency department. Whiskers represent 95% CIs.

ED Visits and Hospitalizations by Race and Ethnicity

A higher proportion of Black and Hispanic decedents with dementia had ED admissions in the last 180 days of life compared with White decedents (645 of 809 [79.7%] and 274 of 357 [76.8%] vs 2753 of 3892 [70.3%]; *P* < .001) (Table 2). Even among dementia beneficiaries enrolled in hospice, 56 of 309 (18.1%) Black and 22 of 153 (14.4%) Hispanic decedents had ED visits at some point after hospice enrollment, compared with 191 of 1967 (9.7%) White decedents (*P* < .001). Admissions to the hospital after hospice enrollment were also more common among Black and Hispanic decedents than among White decedents (48 of 309 [15.5%] and 17 of 153 [11.1%] vs 119 of 1967 [6.0%]; *P* < .001). Overall, Black and Hispanic decedents with dementia had more ED visits (outpatient ED: 2.8 [2.2] and 2.4 [2.1] visits vs 2.5 [2.0] visits; *P* = .06; inpatient ED: 2.2 [1.4] and 1.9 [1.1] visits vs 1.7 [1.1] visits; *P* < .001), more hospitalizations (2.4 [1.5] and 2.3 [1.5] hospitalizations vs 2.0 [1.3] hospitalizations; *P* < .001), and longer hospital length of stay (10.0 [8.5] and 9.6 [6.6] days vs 8.0 [6.6] days; *P* < .001) compared with White decedents. End-of-life outpatient ED expenditures were similar across ethnic and racial groups, whereas estimated mean inpatient expenditures were substantially higher among Black and Hispanic than among White decedents (Black, $23 279; 95% CI, $20 690-$25 868 per dementia decedent; Hispanic, $23 471; 95% CI, $19 532-$27 410 per dementia decedent vs White, $14 609; 95% CI, $13 800-$15 418 per dementia decedent) (Figure 2).

Dementia beneficiaries were most frequently hospitalized for circulatory system diseases at the end of life (1242 of 5270 [23.6%] hospitalizations among White beneficiaries; 330 of 1541 [21.4%] hospitalizations among Black beneficiaries; 117 of 650 [18.0%] hospitalizations among Hispanic beneficiaries), followed by respiratory (986 of 5270 [18.7%] hospitalizations among White beneficiaries; 223 of 1541 [14.5%] hospitalizations among Black beneficiaries; 128 of 650 [19.7%] hospitalizations among Hispanic beneficiaries) and infectious and parasitic diseases (598 of 5270 [11.3%] hospitalizations among White beneficiaries; 250 of 1541 [16.2%] hospitalizations among Black beneficiaries; 98 of 650 [15.1%] hospitalizations among Hispanic beneficiaries) (Table 3). Injury and poisoning, as well as genitourinary, digestive, endocrine, and neoplasm conditions were also common causes of end-of-life hospitalizations in this population. A sizable proportion of these hospitalizations were for potentially avoidable conditions (eTable 2 in the Supplement).

Table 3.

Major Causes of Hospitalizations in the Last 180 Days of Life Among Beneficiaries With Dementia by Race and Ethnicity

Disease category[a]	**Hospitalizations, No. (%)**			
	Non-Hispanic White (n = 5270)	**Non-Hispanic Black (n = 1541)**	**Hispanic (n = 650)**	***P* value**
Circulatory	1242 (23.6)	330 (21.4)	117 (18.0)	.003
Respiratory	986 (18.7)	223 (14.5)	128 (19.7)	<.001
Infectious and parasitic	598 (11.4)	250 (16.2)	98 (15.1)	<.001
Injury and poisoning	495 (9.4)	97 (6.3)	51 (7.9)	<.001
Genitourinary	407 (7.7)	158 (10.3)	59 (9.1)	.005
Digestive	370 (7.0)	85 (5.5)	42 (6.5)	.11
Endocrine	215 (4.1)	96 (6.2)	36 (5.5)	.001
Neoplasms	221 (4.2)	82 (5.3)	27 (4.2)	.16

[a] The table is restricted to major causes of hospitalizations accounting for ≥5% of admissions in any of the analyzed racial or ethnic groups. Principal discharge diagnoses were used to categorize causes of hospitalizations based on the Agency for Healthcare Research and Quality (AHRQ) Clinical Classifications Software (CCS) for *International Classification of Diseases, Ninth Revision, Clinical Modification* (*ICD-9-CM*) codes and the Clinical Classifications Software Refined (CCSR) for *ICD-10-CM* codes.

End-of-Life Care Preferences by Race and Ethnicity

Treatment preferences for end-of-life care among dementia decedents differed substantially by race and ethnicity (Table 2). The proportion of dementia beneficiaries completing advance care planning was lower among Black (146 of 704 [20.7%]) and Hispanic beneficiaries (66 of 308 [21.4%]) compared with White beneficiaries (1871 of 3274 [57.1%]). A higher proportion of Black and Hispanic decedents with dementia had written instructions choosing all care possible to prolong life (30 of 144 [20.8%] and 12 of 65 [18.5%] vs 72 of 1852 [3.9%]), whereas a higher proportion of White beneficiaries preferred to limit care in certain situations (1708 of 1840

[92.8%] vs 114 of 141 [80.9%] and 51 of 64 [79.7%]), withhold treatments (1448 of 1799 [80.5%] vs 87 of 140 [62.1%] and 41 of 62 [66.1%]), and forgo extensive life-prolonging measures (1712 of 1838 [93.1%] vs 120 of 138 [87.0%] and 54 of 65 [83.1%]).

Discussion

Our findings showed substantial ethnic and racial differences in dementia end-of-life care utilization patterns and patient treatment preferences. Black and Hispanic decedents with dementia used less hospice but more ED and inpatient services, and incurred roughly 60% higher Medicare inpatient expenditures at the end of life compared with White decedents. Among hospice users, more Black and Hispanic than White decedents with dementia were subsequently admitted to the ED or hospital before death.

The trends in racial and ethnic differences in end-of-life care observed in our sample of dementia beneficiaries are not entirely surprising given the health care utilization patterns in the overall Medicare population.[18,26,27] Nonetheless, to our knowledge, this is the first study to quantify such differences among racially and ethnically diverse Medicare decedents with dementia in both community and nursing home settings. Understanding how and when individuals with dementia use hospice and other end-of-life care across populations is one of the highest research priorities identified by the National Academies of Sciences, Engineering, and Medicine.[28] Our study provides new evidence highlighting unique end-of-life care utilization and treatment preferences across racial and ethnic groups among patients with dementia.

Race and ethnicity are known to be associated with end-of-life care type and intensity independent of other social determinants of health.[11,27,29,30,31] Studies have suggested several possible reasons, in addition to cultural and religious or spiritual values. For instance, mistrust of the health care system due to medical racism and health inequalities in the US may lead more non-White patients to perceive hospice care as "giving up" and motivate them to request more aggressive, life-sustaining interventions.[18,32,33] Our data showed that although most dementia beneficiaries desire less invasive care at the end of life, preferences to limit care, withhold treatment, or forgo life-prolonging measures were much less common among Black and Hispanic patients.

Additionally, such mistrust may compromise patient-physician communication, reducing access to high-quality end-of-life care. Researchers have documented racial and ethnic inequity in the provision of, and access to, hospice care.[34] In our data, it is unclear which beneficiaries with dementia and family caregivers had physician counseling about end-of-life care, but we found that only 1 in 5 Black and Hispanic decedents with dementia completed advance care planning—a much lower proportion than their White peers.[30] These written instructions give persons with dementia a voice in making end-of-life medical decisions when they become unable to understand or speak for themselves. Dementia education programs should foster community outreach and help patients with dementia and their caregivers understand end-of-life care issues, including the benefits of advance care planning.[30]

Hospice care may improve quality of life of terminally ill patients and their caregivers and reduce Medicare costs.[35,36,37,38,39] In our sample, fewer than half of Medicare decedents with dementia used hospice services during the last 6 months of life. Although hospice is not always the right choice for terminal patients, more beneficiaries with dementia could appropriately benefit from the service. In particular, our results highlighted 2 concerning trends that may limit the full benefits of hospice received by dementia beneficiaries and caregivers. First, the timing of hospice enrollment was suboptimal. We found that almost 1 in 3 beneficiaries with dementia entered hospice very close to the end of life (ie, within 7 days before death) and for a short time period. This proportion was higher compared with the general Medicare population.[3] Second, some dementia beneficiaries in hospice, especially Black and Hispanic beneficiaries, were subsequently admitted to the ED or hospital before death, suggesting a live discharge. Overall, we found that beneficiaries with dementia had similarly frequent ED visits and hospitalizations at the end of life compared with the general Medicare population.[6] Health care professionals make decisions prospectively about whether to admit patients with dementia to the hospital. Some hospitalizations are necessary and expected as part of the natural course of treatment, whereas others may be considered low-value at the end of life. These transitions not only impose burdens on older adults with dementia and their caregivers but also increase mortality and costs.[6,40] Medicare should consider alternative payment models, such as bundling services into an episode of care,[41] as one way to address suboptimal hospice use and burdensome end-of-life transitions among dementia beneficiaries. These strategies would help incentivize high-quality services, reduce low-value, unnecessary ED visits and hospitalizations,[41] and promote end-of-life discussions. Such discussions may reduce aggressive medical interventions near death and facilitate earlier hospice referrals.[39] Medicare could provide more comprehensive reimbursement to hospital-based palliative care teams[6] and reward hospitals for improved access to and delivery of effective hospice care for dementia patients.

Limitations

This study had several limitations. First, we could not ascertain cause of death, a factor that may affect end-of-life care.[18] We did not use diagnoses reported on death certificates because those records likely underreport dementia as an underlying cause of death.[42] Future investigations would benefit from additional efforts, such as expert reviews of death certificates, proxy interviews, and medical record reviews, to determine how our findings differ by cause of death. Second, we relied on diagnosis codes in claims data to identify patients with dementia because HRS lacks a direct measure of dementia status and because there is no uniformly accepted case definition for dementia in observational studies. Our sample may have omitted individuals with undiagnosed dementia, of which a higher proportion are non-White individuals.[22] Third, our sample had too few Asian Americans or patients from other racial or ethnic groups to allow further analyses. Fourth, our analyses were limited to fee-for-service beneficiaries aged 65 years or older, and thus the results might not fully generalize to Medicare Advantage enrollees or younger patients. Fifth, our data spanned from 2000 to 2016; we did not evaluate changes over time in hospital or doctor behavior or Medicare enrollment. For example, enrollment in Medicare Advantage has increased substantially over the last decade, especially among non-White beneficiaries.[43]

Finally, preferences for end-of-life care were based on proxy reports after the study participant's death (ie, HRS did not collect this information prospectively)[25] and therefore recall bias was possible.

Conclusions

Although use of Medicare hospice benefits has increased,[3] our results suggest that end-of-life care for beneficiaries with dementia remains suboptimal, especially for Black and Hispanic patients. The type and intensity of care individuals receive at the end of life is a complex issue, even more so among older adults with dementia because of their impaired ability to plan and communicate care preferences. Doctors and staff should address these communication barriers, especially in underresourced racial and ethnic communities. Medicare should consider alternative payment models to promote culturally competent end-of-life care and reduce low-value interventions and costs among the dementia population.

Notes

Supplement.

eFigure. CONSORT Diagram

eTable 1. Odds Ratios of Hospice Use in the Last 180 Days of Life Among Medicare Decedents With Dementia

eTable 2. Proportions of End-of-Life Hospitalizations for Potentially Avoidable Conditions

Click here for additional data file. (187K, pdf)

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Racial and Ethnic Differences in Hospice Use and Hospitalizations at End-of-Life Among Medicare Beneficiaries With Dementia

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Abstract

IMPORTANCE The pool of studies examining ethnic and racial differences in hospice use and end-of-life hospitalizations among patients with dementia is limited and results are conflicting, making it difficult to assess health care needs of underresourced racial and ethnic groups.

OBJECTIVE To explore differences in end-of-life utilization of hospice and hospital services among patients with dementia by race and ethnicity.

DESIGN, SETTING, AND PARTICIPANTS This cohort study used national survey data from the Health and Retirement Study linked with Medicare and Medicaid claims that reflected a range of socioeconomic, health, and psychosocial characteristics. Eligible participants were Medicare fee-for-service beneficiaries aged 65 years or older diagnosed with dementia who died between 2000 and 2016. Analyses were performed from June to December 2021.

EXPOSURES Race and ethnicity.

MAIN OUTCOMES AND MEASURES We examined the frequency and costs of hospice care, emergency department (ED) visits, and hospitalizations during the last 180 days of life among Medicare decedents with dementia. We analyzed the proportion of dementia decedents with advance care planning and their end-of-life care preferences.

RESULTS The cohort sample included 5058 beneficiaries with dementia (mean [SD] age, 85.5 [8.0] years; 3038 women [60.1%]; 809 [16.0%] non-Hispanic Black, 357 [7.1%] Hispanic, and 3892 non-Hispanic White respondents [76.9%]). In adjusted analysis, non-Hispanic Black decedents (odds ratio [OR], 0.65; 95% CI, 0.55-0.78), nursing home residents (OR, 0.81; 95% CI, 0.71-0.93), and survey respondents represented by a proxy (OR, 0.84; 95% CI, 0.71-0.99) were less likely to use hospice, whereas older decedents (age 75-84 vs 65-74 years: OR, 1.39; 95% CI, 1.12-1.72; age ≥85 vs 65-74 years: OR, 1.39; 95% CI, 1.13-1.71), women (OR, 1.19; 95% CI, 1.05-1.35), and decedents with higher education (high school vs less than high school: OR, 1.17; 95% CI, 1.01-1.36; more than high school vs less than high school: OR, 1.32; 95% CI, 1.13-1.54), more severe cognitive impairment (OR, 1.51; 95% CI, 1.02-2.23), and more instrumental activities of daily living limitations (OR, 1.07; 95% CI, 1.01-1.12) were associated with higher hospice enrollment. A higher proportion of Black and Hispanic decedents with dementia used ED (645 of 809 [79.7%] and 274 of 357 [76.8%] vs 2753 of 3892 [70.7%]; *P* < .001) and inpatient services (625 of 809 [77.3%] and 275 of 357 [77.0%] vs 2630 of 3892 [67.5%]; *P* < .001) and incurred roughly 60% higher inpatient expenditures at the end of life compared with White decedents (estimated mean: Black, $23 279; 95% CI, $20 690-$25 868; Hispanic, $23 471; 95% CI, $19 532-$27 410 vs White, $14 609; 95% CI, $13 800-$15 418). A higher proportion of Black and Hispanic than White beneficiaries with dementia who were enrolled in hospice were subsequently admitted to the ED (56 of 309 [18.1%] and 22 of 153 [14.4%] vs 191 of

(continued)

Key Points

Question How does use of hospice and hospital services at the end of life differ by race and ethnicity among patients with dementia?

Findings This cohort study found that non-Hispanic Black and Hispanic decedents with dementia used less hospice but more emergency department and inpatient services, and incurred roughly 60% higher Medicare inpatient expenditures at the end of life, compared with non-Hispanic White decedents. The proportion of dementia beneficiaries completing advance care planning was significantly lower among non-Hispanic Black and Hispanic decedents compared with non-Hispanic White decedents.

Meaning These results highlight the importance of understanding how end-of-life care utilization and treatment preferences among patients with dementia differ across racial and ethnic groups.

+ Invited Commentary

+ Supplemental content

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Abstract (continued)

1967 [9.7%]; $P < .001$) or hospital (48 of 309 [15.5%] and 17 of 153 [11.1%] vs 119 of 1967 [6.0%]; $P < .001$) before death. The proportion of dementia beneficiaries completing advance care planning was lower among Black (146 of 704 [20.7%]) and Hispanic (66 of 308 [21.4%]) beneficiaries compared with White beneficiaries (1871 of 3274 [57.1%]). A higher proportion of Black and Hispanic decedents with dementia had written instructions choosing all care possible to prolong life (30 of 144 [20.8%] and 12 of 65 [18.4%] vs 72 of 1852 [3.9%]), whereas a higher proportion of White decedents preferred to limit care in certain situations (1708 of 1840 [92.8%] vs 114 of 141 [80.9%] and 51 of 64 [79.7%]), withhold treatments (1448 of 1799 [80.5%] vs 87 of 140 [62.1%] and 41 of 62 [66.1%]), and forgo extensive life-prolonging measures (1712 of 1838 [93.1%] vs 120 of 138 [87.0%] and 54 of 65 [83.1%]).

CONCLUSIONS AND RELEVANCE The results of this cohort study highlight unique end-of-life care utilization and treatment preferences across racial and ethnic groups among patients with dementia. Medicare should consider alternative payment models to promote culturally competent end-of-life care and reduce low-value interventions and costs among the population with dementia.

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Introduction

Despite advances in dementia prevention and treatment,[1] end-of-life care remains critically important for all individuals living with the condition. Hospice, for example, provides comfort care and support for terminal patients and their families. Older adults with dementia are among those who are most likely to benefit from end-of-life hospice care because these individuals often experience multiple distressing symptoms (eg, pain, depression, and delusions) and poor quality of life.[2] To qualify for the Medicare hospice benefit, a patient must be certified by 2 physicians as terminally ill, defined as having a medical prognosis of 6 months or less.[3] However, prognostic challenges in dementia, such as its long disease duration and unpredictable trajectories, make certifying eligibility for the Medicare hospice benefit difficult. Although hospice utilization in the Medicare population has increased in recent decades, the service remains underused, with only half of Medicare decedents enrolling in the hospice benefit.[3-5] Individuals with noncancer illness, including those with dementia, and from underserved communities have lower hospice utilization rates.[5-8]

Some evidence suggests that, among individuals with dementia, non-Hispanic Black individuals experience more aggressive end-of-life care (eg, artificial nutrition, mechanical ventilation, and intensive care unit admissions) compared with non-Hispanic White individuals.[9-11] However, the pool of studies examining racial and ethnic differences in hospice use and end-of-life hospitalizations among patients with dementia is limited and the results conflicting.[9] For example, one analysis of nursing home residents with advanced dementia in Boston found that Black individuals were more likely than White to receive hospice referrals,[12] whereas a US national study suggested that hospice use was lower among Black residents.[13] The type and intensity of care individuals receive at the end of life may differ for those with more advanced dementia,[10] but claims-based analyses lack sufficient clinical detail to characterize cognitive function. Furthermore, while studies have examined dementia end-of-life care, the analyses often are restricted to nursing home residents.[14-16] These estimates are limited because they omit a substantial proportion of dementia patients living at home or other settings prior to death.[6] The samples typically lack racial and ethnic diversity, and thus robust data on non-White decedents with dementia are sparse.[9] For example, prior examinations of hospice use have compared differences between Black and White patients with dementia but lacked data on other racial or ethnic groups.[14,17,18] The limitations of previous analyses, such as a lack of dementia severity measures and use of unrepresentative samples, make it difficult to assess unique end-of-life care needs for underresourced racial and ethnic groups.

This study examined the frequency and costs of end-of-life hospice care, emergency department (ED) visits, and hospitalizations among Medicare decedents with dementia. Our study extends existing research by analyzing how dementia end-of-life care utilization patterns differ by race and ethnicity. We supplemented claims data with national survey data that included measures of cognitive function and socioeconomic factors known to affect end-of-life care. We also analyzed ethnic and racial differences in patient instructions regarding end-of-life treatment based on survey data. Our sample included community-dwelling patients and nursing home residents, thus making our findings more representative of the general dementia population. We hypothesized that non-Hispanic Black and Hispanic patients with dementia had lower hospice use but more ED and hospital admissions at the end of life compared with non-Hispanic White patients.

Methods

The Tufts Medical Center/Tufts University Health Sciences institutional review board approved this cohort study via expedited review procedures per 45 CFR 46.110(b)(4); informed consent was not required because the study analyzed existing, secondary data. We followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.

Data and Sample

We used data from the 2000-2016 Health and Retirement Study (HRS) linked with Medicare and Medicaid claims. The HRS is a nationally representative biennial survey of US adults aged 50 or older, collecting a range of respondent socioeconomic, health, and psychosocial characteristics.[19] Each wave of HRS interviews roughly 20 000 respondents, with response rates ranging from 81% to 89%.[20] The HRS oversamples Black and Hispanic households, making it well suited for our investigation of racial and ethnic disparities. We used HRS survey data linked to respondents' Medicare fee-for-service part A (ie, inpatient, skilled nursing facility, hospice, and home health), part B (ie, physician visit, outpatient care, and durable medical equipment), and part D (ie, prescription drug) claims, as well as Medicaid analytic extracts and summary files for dually eligible beneficiaries. These health insurance claims included diagnosis codes, medical and prescription drug utilization, date of service, and reimbursement for all services rendered.

Our sample included HRS respondents aged 65 years and older diagnosed with dementia who died between 2000 and 2016 (eFigure in the Supplement). We identified individuals with a claims-based diagnosis of dementia during the study period by using *International Classification of Diseases, Ninth* or *Tenth Revisions* diagnosis codes.[21,22] We required all patients to have continuous enrollment in Medicare fee-for-service for at least 6 months prior to death.

Outcome Measures

Hospice

We used HRS-linked Medicare claims to analyze the proportion of dementia decedents enrolling in hospice during the last 180 days of life and their cumulative hospice days and hospice expenditures paid by Medicare. We also examined late hospice enrollment (within 7 and 3 days before death) as an indicator of poor end-of-life care quality.

ED Visits and Hospitalizations

We examined the average number of outpatient ED visits, inpatient ED visits, and hospital stays during the last 180 days of life, as well as Medicare expenditures for these visits. We calculated total expenditures for inpatient ED and hospital admissions combined because those payments cannot be separately identified in Medicare claims.

We identified major causes of hospitalizations based on principal discharge diagnoses, using the Agency for Healthcare Research and Quality (AHRQ) Clinical Classifications Software (CCS) and Clinical Classifications Software Refined (CCSR) tools.[12,23] Additionally, we examined the proportion of potentially avoidable hospitalizations for ambulatory care sensitive chronic conditions (ie, hypertension, diabetes, asthma, chronic obstructive pulmonary disease, and heart failure) and acute infections (ie, bacterial pneumonia and urinary tract infection), as defined by the AHRQ Prevention Quality Indicators, version 2021.[24]

End-of-Life Care Preferences

We examined patient end-of-life care preferences using the HRS exit interview data reported by a proxy within 2 years after the study participant's death.[25] The interview asked whether the participant had advance care planning, ie, written instructions specifying the treatment or care they wanted to receive during the final days of life. Of those study participants with advance care planning, the interview asked whether these instructions expressed any desire to: (1) receive all care possible to prolong life; (2) limit care in certain situations; (3) have any treatment withheld; or (4) keep them comfortable and pain free but forego extensive measures to prolong life (choices not mutually exclusive; each categorized as yes or no).

Statistical Analysis

We developed 2-part models to assess whether Medicare expenditures for hospice, outpatient ED, and inpatient services differed by race and ethnicity, categorized as non-Hispanic White, non-Hispanic Black, and Hispanic. The first part used a logistic regression to estimate the probability of any use; the second part used a generalized linear model (GLM) with log link and γ distribution to estimate mean expenditures among users. Combining results from these 2 model components yielded population expenditure estimates. We standardized all Medicare expenditures to 2016 US$.

Covariates in both logistic regression and GLM included age, sex, education, cognition, functional limitations, comorbidities, Medicare-Medicaid dual eligibility, nursing home status, and proxy respondent. We measured cognition using HRS-imputed Telephone Interview for Cognitive Status (TICS) scores for self-respondents and Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) scores for those study participants represented by a proxy. We quantified functional status in terms of the number of limitations in activities of daily living (ADL; including getting dressed, walking across the room, bathing, eating, getting in and out of bed, and using the toilet) and instrumental ADL (IADL; including preparing meals, shopping for groceries, using the telephone, taking medication, and managing one's money). For end-of-life care preferences, we analyzed the proportion of beneficiaries with advance care planning and their specific instructions (as detailed in "Outcome measures") by race and ethnicity. All analyses were performed from June to December 2021.

Results

Sample Characteristics

Our study sample included 5058 beneficiaries with dementia; 3892 beneficiaries (76.9%) were non-Hispanic White, 809 (16.0%) were non-Hispanic Black, and 357 (7.1%) were Hispanic. Overall, the mean (SD) age of beneficiaries was 85.5 (8.0) years and 3038 participants were women (60.1%) (**Table 1**). Compared with Black and Hispanic decedents, White decedents with dementia were older (mean age [SD]: 85.9 [7.7] years vs Black, 84.0 [8.8] years and Hispanic, 84.0 [8.6] years; $P < .001$), had higher education levels (1234 of 3892 [31.7%] completed more than high school vs 117 of 809 Black decedents [14.5%] and 40 of 357 Hispanic decedents [11.2%]; $P < .001$), better cognitive scores (mean [SD] TICS scores: 15.9 [6.2] vs Black, 12.5 [6.0] and Hispanic, 13.6 [5.3]; mean [SD] IQCODE scores: 4.1 [0.8] vs 3.9 [0.8] and 4.0 [0.8]; $P < .001$), and fewer functional limitations (eg, mean [SD] IADL limitations: 2.1 [1.8] vs Black, 2.2 [1.9] and Hispanic, 2.3 [1.9]; $P = .006$), were more likely to live in a nursing home (1805 of 3666 [49.2%] vs 336 of 766 Black decedents [43.9%] and 127 of 341 Hispanic decedents [37.2%]; $P < .001$) and less likely to be dually eligible for Medicare and Medicaid (741 of 3892 [19.0%] vs 286 of 809 Black decedents [35.4%] and 169 of 357 Hispanic decedents [47.3%]; $P < .001$).

Hospice Care by Race and Ethnicity

Less than half of the decedents with dementia in our sample (2429 of 5058 [48.0%]) used hospice care in their last 180 days of life (**Table 2**). The proportion was lower among Black and Hispanic compared with White decedents (309 of 809 [38.2%] and 153 of 357 [42.9%] vs 1967 of 3892 [50.5%], $P < .001$). In adjusted analysis, Black decedents (odds ratio [OR]: 0.65; 95% CI, 0.55-0.78), nursing home residents (OR, 0.81; 95% CI, 0.71-0.93), and respondents represented by a proxy were less likely to use hospice (OR, 0.84; 95% CI, 0.71-0.99), whereas older age (75-84 vs 65-74 years: OR, 1.39; 95% CI, 1.12-1.72; ≥85 vs 65-74 years: OR, 1.39; 95% CI, 1.13-1.71), women (OR, 1.19; 95% CI, 1.05-1.35), higher education (high school vs less than high school: OR, 1.17; 95% CI, 1.01-1.36; more than high school vs less than high school: OR, 1.32; 95% CI, 1.13-1.54), more severe cognitive impairment (OR, 1.51; 95% CI, 1.02-2.23), and more IADL limitations (OR, 1.07; 95% CI, 1.01-1.12) were associated with higher hospice enrollment (eTable 1 in the Supplement).

Among hospice users, the mean (SD) length of stay was 1.6 (2.0) months, and Hispanic decedents with dementia had the shortest stays (mean [SD] stay: White, 50.4 [61.8] days; Black, 50.1 [59.9] days; Hispanic, 43.5 [57.4] days; $P = .41$) (**Figure 1**). Late hospice enrollment was common across all racial and ethnic groups; overall, 735 of 2429 beneficiaries with dementia (30.3%) entered only during the last 7 days of life, and 334 of 2429 (13.8%) only during the last 3 days of life. Model estimated mean Medicare hospice expenditures did not differ significantly by race or ethnicity: $4097 (95% CI, $3835-$4360) per dementia decedent among White beneficiaries, $3417 (95% CI, $2858-$3976) among Black beneficiaries, and $3372 (95% CI, $2605-$4140) among Hispanic beneficiaries (**Figure 2**).

Table 1. Sample Characteristics

Characteristic	Respondents, No. (%) Total (n = 5058)	Non-Hispanic White (n = 3892)	Non-Hispanic Black (n = 809)	Hispanic (n = 357)	P value
Age, mean (SD), y	85.5 (8.0)	85.9 (7.7)	84.0 (8.8)	84.0 (8.6)	<.001
Age category, y					
65-74	587 (11.6)	381 (9.8)	148 (18.3)	58 (16.3)	<.001
75-84	1667 (33.0)	1256 (32.3)	279 (34.5)	132 (37.0)	
≥85	2804 (55.4)	2255 (57.9)	382 (47.2)	167 (46.8)	
Sex					
Women	3038 (60.1)	2325 (59.7)	509 (62.9)	204 (57.1)	.12
Men	2020 (39.9)	1567 (40.3)	300 (37.1)	153 (42.9)	
Education					
<High school	2124 (42.0)	1322 (34.0)	527 (65.1)	275 (77.0)	<.001
High school	1543 (30.5)	1336 (34.3)	165 (20.4)	42 (11.8)	
>High school	1391 (27.5)	1234 (31.7)	117 (14.5)	40 (11.2)	
Medicare-Medicaid dual eligibility	1196 (23.7)	741 (19.0)	286 (35.4)	169 (47.3)	<.001
Nursing home resident	2268 (47.5)	1805 (49.2)	336 (43.9)	127 (37.2)	<.001
Proxy respondent	2013 (42.4)	1494 (40.9)	350 (46.1)	169 (49.6)	<.001
TICS scores, mean (SD)[a]	15.3 (6.2)	15.9 (6.2)	12.5 (6.0)	13.6 (5.3)	<.001
IQCODE scores, mean (SD)[a]	4.1 (0.8)	4.1 (0.8)	3.9 (0.8)	4.0 (0.8)	<.001
ADL limitations, mean (SD)	2.1 (2.1)	2.1 (2.1)	2.1 (2.1)	2.4 (2.2)	.04
IADL limitations, mean (SD)	2.1 (1.8)	2.1 (1.8)	2.2 (1.9)	2.3 (1.9)	.006
Comorbidities, mean (SD)[b]	3.3 (1.6)	3.3 (1.6)	3.4 (1.5)	3.4 (1.6)	.17

Abbreviations: ADL, activities of daily living; IADL, instrumental activities of daily living; IQCODE, Informant Questionnaire on Cognitive Decline in the Elderly; TICS, Telephone Interview for Cognitive Status.

[a] TICS scores were available for self-respondents (2702 respondents) and IQCODE scores were available for those represented by a proxy (1763 respondents).

[b] Comorbidity count ranged from 0 to 8, including high blood pressure, diabetes, cancer, lung disease, heart disease, stroke, psychiatric problems, and arthritis, based on HRS survey data.

ED Visits and Hospitalizations by Race and Ethnicity

A higher proportion of Black and Hispanic decedents with dementia had ED admissions in the last 180 days of life compared with White decedents (645 of 809 [79.7%] and 274 of 357 [76.8%] vs 2753 of 3892 [70.3%]; $P < .001$) (Table 2). Even among dementia beneficiaries enrolled in hospice, 56 of 309 (18.1%) Black and 22 of 153 (14.4%) Hispanic decedents had ED visits at some point after

Table 2. Unadjusted Hospice Use, Emergency Department Visits, and Hospitalizations in the Last 180 Days of Life and End-of-Life Care Preferences Among Dementia Decedents by Race and Ethnicity

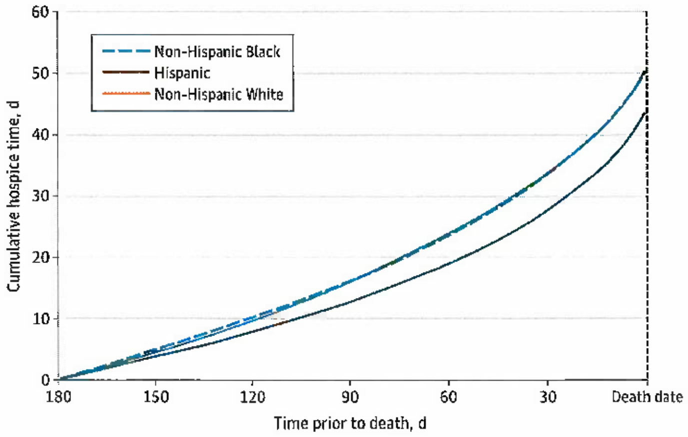
	Respondents, No. (%)				
End-of-life service	All (N = 5058)	Non-Hispanic White (n = 3892)	Non-Hispanic Black (n = 809)	Hispanic (n = 357)	P value
Hospice care					
Any hospice enrollment	2429 (48.0)	1967 (50.5)	309 (38.2)	153 (42.9)	<.001
Total hospice days, mean (SD), d[a]	49.9 (61.3)	50.4 (61.8)	50.1 (59.9)	43.5 (57.4)	.41
Hospice enrollment only during the last 7 d of life[a]	735 (30.3)	606 (30.8)	84 (27.2)	45 (29.4)	.42
Hospice enrollment only during the last 3 d of life[a]	334 (13.8)	269 (13.7)	43 (13.9)	22 (14.4)	.97
ED visits					
Any visit after hospice enrollment	269 (11.1)	191 (9.7)	56 (18.1)	22 (14.4)	<.001
Any visit	3672 (72.6)	2753 (70.7)	645 (79.7)	274 (76.8)	<.001
Total No. of outpatient visits, mean (SD)[a]	2.5 (2.1)	2.5 (2.0)	2.8 (2.2)	2.4 (2.1)	.06
Total No. of inpatient visits, mean (SD)[a]	1.8 (1.2)	1.7 (1.1)	2.2 (1.4)	1.9 (1.1)	<.001
Hospitalization					
Any hospitalization after hospice enrollment	184 (7.6)	119 (6.1)	48 (15.5)	17 (11.1)	<.001
Any hospitalization	3530 (69.8)	2630 (67.6)	625 (77.3)	275 (77.0)	<.001
Total No. of hospitalizations, mean (SD)[a]	2.1 (1.4)	2.0 (1.3)	2.4 (1.5)	2.3 (1.5)	<.001
Length of stay, mean (SD), d[a]	8.5 (7.0)	8.0 (6.6)	10.0 (8.5)	9.6 (6.6)	<.001
Advance care planning (4286 respondents)	2083 (48.6)	1871 (57.2)	146 (20.7)	66 (21.4)	NA
All care possible to prolong life (2061 respondents)	114 (5.5)	72 (3.9)	30 (20.8)	12 (18.5)	NA
Limited care (2045 respondents)	1873 (91.6)	1708 (92.8)	114 (80.9)	51 (79.7)	NA
Any treatment withheld (2001 respondents)	1576 (78.8)	1448 (80.5)	87 (62.1)	41 (66.1)	NA
Comfortable and pain free but forego extensive measures to prolong life (2041 respondents)	1886 (92.4)	1712 (93.1)	120 (87.0)	54 (83.1)	NA

Abbreviation: ED, emergency department.

These are unadjusted, descriptive statistics. P values were based on χ^2 tests (categorical variables) and ANOVA tests (continuous variables).

[a] Among users.

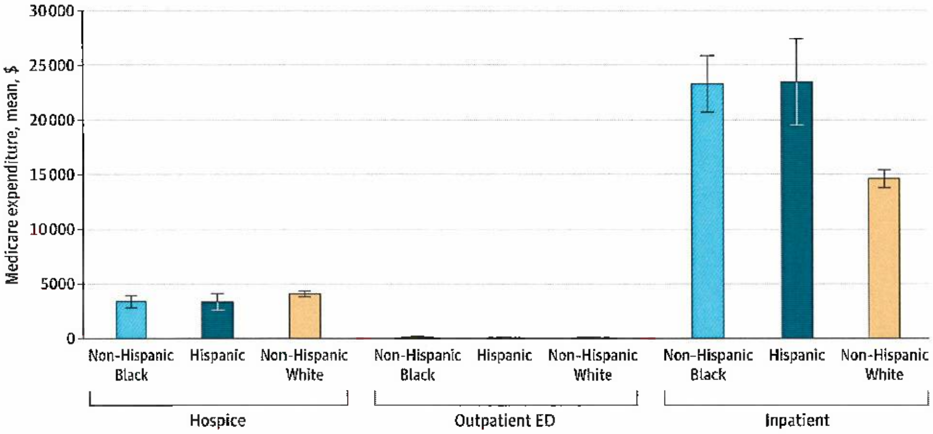
Figure 1. Cumulative Hospice Days in the Last 180 Days of Life Among Dementia Beneficiaries Enrolling in Hospice Care, by Race and Ethnicity



hospice enrollment, compared with 191 of 1967 (9.7%) White decedents ($P < .001$). Admissions to the hospital after hospice enrollment were also more common among Black and Hispanic decedents than among White decedents (48 of 309 [15.5%] and 17 of 153 [11.1%] vs 119 of 1967 [6.0%]; $P < .001$). Overall, Black and Hispanic decedents with dementia had more ED visits (outpatient ED: 2.8 [2.2] and 2.4 [2.1] visits vs 2.5 [2.0] visits; $P = .06$; inpatient ED: 2.2 [1.4] and 1.9 [1.1] visits vs 1.7 [1.1] visits; $P < .001$), more hospitalizations (2.4 [1.5] and 2.3 [1.5] hospitalizations vs 2.0 [1.3] hospitalizations; $P < .001$), and longer hospital length of stay (10.0 [8.5] and 9.6 [6.6] days vs 8.0 [6.6] days; $P < .001$) compared with White decedents. End-of-life outpatient ED expenditures were similar across ethnic and racial groups, whereas estimated mean inpatient expenditures were substantially higher among Black and Hispanic than among White decedents (Black, \$23 279; 95% CI, \$20 690-\$25 868 per dementia decedent; Hispanic, \$23 471; 95% CI, \$19 532-\$27 410 per dementia decedent vs White, \$14 609; 95% CI, \$13 800-\$15 418 per dementia decedent) (Figure 2).

Dementia beneficiaries were most frequently hospitalized for circulatory system diseases at the end of life (1242 of 5270 [23.6%] hospitalizations among White beneficiaries; 330 of 1541 [21.4%] hospitalizations among Black beneficiaries; 117 of 650 [18.0%] hospitalizations among Hispanic beneficiaries), followed by respiratory (986 of 5270 [18.7%] hospitalizations among White beneficiaries; 223 of 1541 [14.5%] hospitalizations among Black beneficiaries; 128 of 650 [19.7%] hospitalizations among Hispanic beneficiaries) and infectious and parasitic diseases (598 of 5270 [11.3%] hospitalizations among White beneficiaries; 250 of 1541 [16.2%] hospitalizations among Black beneficiaries; 98 of 650 [15.1%] hospitalizations among Hispanic beneficiaries) (**Table 3**). Injury and poisoning, as well as genitourinary, digestive, endocrine, and neoplasm conditions were also

Figure 2. Estimated Mean Medicare Expenditures per Dementia Decedent in the Last 180 Days of Life



ED indicates emergency department. Whiskers represent 95% CIs.

Table 3. Major Causes of Hospitalizations in the Last 180 Days of Life Among Beneficiaries With Dementia by Race and Ethnicity

	Hospitalizations, No. (%)			
Disease category[a]	Non-Hispanic White (n = 5270)	Non-Hispanic Black (n = 1541)	Hispanic (n = 650)	P value
Circulatory	1242 (23.6)	330 (21.4)	117 (18.0)	.003
Respiratory	986 (18.7)	223 (14.5)	128 (19.7)	<.001
Infectious and parasitic	598 (11.4)	250 (16.2)	98 (15.1)	<.001
Injury and poisoning	495 (9.4)	97 (6.3)	51 (7.9)	<.001
Genitourinary	407 (7.7)	158 (10.3)	59 (9.1)	.005
Digestive	370 (7.0)	85 (5.5)	42 (6.5)	.11
Endocrine	215 (4.1)	96 (6.2)	36 (5.5)	.001
Neoplasms	221 (4.2)	82 (5.3)	27 (4.2)	.16

[a] The table is restricted to major causes of hospitalizations accounting for ≥5% of admissions in any of the analyzed racial or ethnic groups. Principal discharge diagnoses were used to categorize causes of hospitalizations based on the Agency for Healthcare Research and Quality (AHRQ) Clinical Classifications Software (CCS) for *International Classification of Diseases, Ninth Revision, Clinical Modification* (*ICD-9-CM*) codes and the Clinical Classifications Software Refined (CCSR) for *ICD-10-CM* codes.

common causes of end-of-life hospitalizations in this population. A sizable proportion of these hospitalizations were for potentially avoidable conditions (eTable 2 in the Supplement).

End-of-Life Care Preferences by Race and Ethnicity

Treatment preferences for end-of-life care among dementia decedents differed substantially by race and ethnicity (Table 2). The proportion of dementia beneficiaries completing advance care planning was lower among Black (146 of 704 [20.7%]) and Hispanic beneficiaries (66 of 308 [21.4%]) compared with White beneficiaries (1871 of 3274 [57.1%]). A higher proportion of Black and Hispanic decedents with dementia had written instructions choosing all care possible to prolong life (30 of 144 [20.8%] and 12 of 65 [18.5%] vs 72 of 1852 [3.9%]), whereas a higher proportion of White beneficiaries preferred to limit care in certain situations (1708 of 1840 [92.8%] vs 114 of 141 [80.9%] and 51 of 64 [79.7%]), withhold treatments (1448 of 1799 [80.5%] vs 87 of 140 [62.1%] and 41 of 62 [66.1%]), and forgo extensive life-prolonging measures (1712 of 1838 [93.1%] vs 120 of 138 [87.0%] and 54 of 65 [83.1%]).

Discussion

Our findings showed substantial ethnic and racial differences in dementia end-of-life care utilization patterns and patient treatment preferences. Black and Hispanic decedents with dementia used less hospice but more ED and inpatient services, and incurred roughly 60% higher Medicare inpatient expenditures at the end of life compared with White decedents. Among hospice users, more Black and Hispanic than White decedents with dementia were subsequently admitted to the ED or hospital before death.

The trends in racial and ethnic differences in end-of-life care observed in our sample of dementia beneficiaries are not entirely surprising given the health care utilization patterns in the overall Medicare population.[18,26,27] Nonetheless, to our knowledge, this is the first study to quantify such differences among racially and ethnically diverse Medicare decedents with dementia in both community and nursing home settings. Understanding how and when individuals with dementia use hospice and other end-of-life care across populations is one of the highest research priorities identified by the National Academies of Sciences, Engineering, and Medicine.[28] Our study provides new evidence highlighting unique end-of-life care utilization and treatment preferences across racial and ethnic groups among patients with dementia.

Race and ethnicity are known to be associated with end-of-life care type and intensity independent of other social determinants of health.[11,27,29-31] Studies have suggested several possible reasons, in addition to cultural and religious or spiritual values. For instance, mistrust of the health care system due to medical racism and health inequalities in the US may lead more non-White patients to perceive hospice care as "giving up" and motivate them to request more aggressive, life-sustaining interventions.[18,32,33] Our data showed that although most dementia beneficiaries desire less invasive care at the end of life, preferences to limit care, withhold treatment, or forgo life-prolonging measures were much less common among Black and Hispanic patients.

Additionally, such mistrust may compromise patient-physician communication, reducing access to high-quality end-of-life care. Researchers have documented racial and ethnic inequity in the provision of, and access to, hospice care.[34] In our data, it is unclear which beneficiaries with dementia and family caregivers had physician counseling about end-of-life care, but we found that only 1 in 5 Black and Hispanic decedents with dementia completed advance care planning—a much lower proportion than their White peers.[30] These written instructions give persons with dementia a voice in making end-of-life medical decisions when they become unable to understand or speak for themselves. Dementia education programs should foster community outreach and help patients with dementia and their caregivers understand end-of-life care issues, including the benefits of advance care planning.[30]

Hospice care may improve quality of life of terminally ill patients and their caregivers and reduce Medicare costs.[35-39] In our sample, fewer than half of Medicare decedents with dementia used hospice services during the last 6 months of life. Although hospice is not always the right choice for terminal patients, more beneficiaries with dementia could appropriately benefit from the service. In particular, our results highlighted 2 concerning trends that may limit the full benefits of hospice received by dementia beneficiaries and caregivers. First, the timing of hospice enrollment was suboptimal. We found that almost 1 in 3 beneficiaries with dementia entered hospice very close to the end of life (ie, within 7 days before death) and for a short time period. This proportion was higher compared with the general Medicare population.[3] Second, some dementia beneficiaries in hospice, especially Black and Hispanic beneficiaries, were subsequently admitted to the ED or hospital before death, suggesting a live discharge. Overall, we found that beneficiaries with dementia had similarly frequent ED visits and hospitalizations at the end of life compared with the general Medicare population.[6] Health care professionals make decisions prospectively about whether to admit patients with dementia to the hospital. Some hospitalizations are necessary and expected as part of the natural course of treatment, whereas others may be considered low-value at the end of life. These transitions not only impose burdens on older adults with dementia and their caregivers but also increase mortality and costs.[6,40] Medicare should consider alternative payment models, such as bundling services into an episode of care,[41] as one way to address suboptimal hospice use and burdensome end-of-life transitions among dementia beneficiaries. These strategies would help incentivize high-quality services, reduce low-value, unnecessary ED visits and hospitalizations,[41] and promote end-of-life discussions. Such discussions may reduce aggressive medical interventions near death and facilitate earlier hospice referrals.[39] Medicare could provide more comprehensive reimbursement to hospital-based palliative care teams[6] and reward hospitals for improved access to and delivery of effective hospice care for dementia patients.

Limitations

This study had several limitations. First, we could not ascertain cause of death, a factor that may affect end-of-life care.[18] We did not use diagnoses reported on death certificates because those records likely underreport dementia as an underlying cause of death.[42] Future investigations would benefit from additional efforts, such as expert reviews of death certificates, proxy interviews, and medical record reviews, to determine how our findings differ by cause of death. Second, we relied on diagnosis codes in claims data to identify patients with dementia because HRS lacks a direct measure of dementia status and because there is no uniformly accepted case definition for dementia in observational studies. Our sample may have omitted individuals with undiagnosed dementia, of which a higher proportion are non-White individuals.[22] Third, our sample had too few Asian Americans or patients from other racial or ethnic groups to allow further analyses. Fourth, our analyses were limited to fee-for-service beneficiaries aged 65 years or older, and thus the results might not fully generalize to Medicare Advantage enrollees or younger patients. Fifth, our data spanned from 2000 to 2016; we did not evaluate changes over time in hospital or doctor behavior or Medicare enrollment. For example, enrollment in Medicare Advantage has increased substantially over the last decade, especially among non-White beneficiaries.[43] Finally, preferences for end-of-life care were based on proxy reports after the study participant's death (ie, HRS did not collect this information prospectively)[25] and therefore recall bias was possible.

Conclusions

Although use of Medicare hospice benefits has increased,[3] our results suggest that end-of-life care for beneficiaries with dementia remains suboptimal, especially for Black and Hispanic patients. The type and intensity of care individuals receive at the end of life is a complex issue, even more so among older adults with dementia because of their impaired ability to plan and communicate care preferences. Doctors and staff should address these communication barriers, especially in underresourced racial and ethnic communities. Medicare should consider alternative payment models to promote culturally competent end-of-life care and reduce low-value interventions and costs among the dementia population.

ARTICLE INFORMATION

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SUPPLEMENT.

eFigure. CONSORT Diagram

eTable 1. Odds Ratios of Hospice Use in the Last 180 Days of Life Among Medicare Decedents With Dementia

eTable 2. Proportions of End-of-Life Hospitalizations for Potentially Avoidable Conditions

2022 Hospice Information Gathering Report

Health Equity in the Hospice Setting

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Cambridge, MA 02138

**The authors used iThenicate software to confirm this document represents an original work and, where applicable, has properly cited the work of others.*

Table of Contents

Table of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMA	American Medical Association
BIPOC	Black, Indigenous, and People of Color
CAHPS®	Hospice Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare and Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
FR	Final Rule
FY	Fiscal Year
HDAH	Healthy Days at Home
HOPE	Hospice Outcomes and Patient Evaluation
HQRP	Hospice Quality Reporting Program
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and other sexual orientations and identities
NHATS	National Health and Aging Trends Survey
NHPCO	National Hospice and Palliative Care Organization
RFI	Request for Information
SDOH	Social Determinants of Health
SOGI	Sexual Orientation and Gender Identity
SVI	Social Vulnerability Index
TEP	Technical Expert Panel

Executive Summary

Background

Many Americans rely on hospice care for end-of-life support. In 2019, more than 1.6 million Medicare beneficiaries received hospice care, with Medicare spending $20.9 billion on hospice services (MedPAC, 2021). High quality hospice services are critical to terminally ill patients. CMS anticipates expanding its Hospice Quality Reporting Program (HQRP) over the next several years to include additional meaningful quality measures to help consumers make informed decisions when selecting a hospice for end-of-life-support.

Since the release of Abt's 2021 Information Gathering Report, the agency released its Framework for Health Equity which considers addressing health disparities in all of it programs, including the HQRP. Additionally, CMS requested information on a potential structural measure to address health equity in the hospice setting.[1] After discussion with federal stakeholders and the hospice quality measure development team, Abt staff identified health-equity as a key area where additional information could support HQRP expansion.

This 2022 Information Gathering Report reflects four main information gathering activities:

1. Updating Abt's 2020 social determinants of health (SDOH) literature review
2. Conducting interviews with experts on health equity in the hospice setting
3. Conducting a literature review focused on health equity in the hospice setting
4. Conducting a literature review for recent quality-related hospice activities

And presents these findings using the following five themes:

1. Discussing health equity
2. Access to and enrollment in hospice
3. Receipt of hospice care
4. Addressing hospice inequities
5. Other recent hospice literature

Discussing Health Equity

CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes"[2]. While this definition is widely accepted, linguistic choices that contribute to marginalizing some subpopulations remain prominent. Deficit-based language focuses on the absence of certain characteristics (e.g., non-white) or defining others by their least desirable characteristics (e.g., lacking trust). Reframing language in ways that do not "blame" the patient for such

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[1] See 87 FR 19422

[2] https://www.cms.gov/pillar/health-equity

disparities may aid in dismantling implicit bias that can create barriers to equitable hospice care. Sometimes overly inclusive terms, even if well-intentioned, can reinforce marginalization by serving as "catch all" phrases that either substitute for deficit-based language, or further obscure the groups they intend to represent – masking important variations in sub-group hospice experiences and outcomes. Examples include "minority" and Black, Indigenous, and People of Color (BIPOC), which are often used as synonyms for non-white.

Access to and Enrollment in Hospice

Historically excluded populations, including Black, Hispanic, Asian, and Indigenous Americans, are less likely to use hospice care than their white counterparts. Differences in referral patterns do not seem to be a contributing factor. In fact, recent literature suggests that Black patients are more likely to receive hospice or palliative care referrals, though this finding was not consistent across all studies and differences appear to be more common across facilities than within facilities. Overall, white patients are more likely to be aware of hospice and its benefits, but the reasons historically excluded populations are less likely to use hospice are more nuanced and complex. Other sociodemographic factors associated with the likelihood of hospice use include gender, education levels, how disenfranchised a patient's neighborhood is, income levels, rurality, primary language, hospice-specific characteristics, and patient preferences.

With respect to timing and type of enrollment, among patients that enroll in hospice, Black and Hispanic patients tend to enroll earlier than their white counterparts, though they may stay in the hospital longer before transitioning to hospice. Findings regarding factors associated with type of enrollment (i.e., home-based vs. facility-based hospice) are mixed. One study[3] found that hospice providers in neighborhoods with higher proportions of women or Hispanic beneficiaries were less likely to provide home hospice care than facility-based hospice care; similarly, another study[4] found that white patients were more likely to receive continuous home care than patients of other races. In contrast, a third study[5] found that Black, Hispanic, and female patients were more likely to receive home hospice care as compared to white patients, and an additional small qualitative study[6] found that Animist and Christian Hmong elders prefer at-home care.

Receipt of Hospice Care

Several studies have considered the patient experience for those enrolled in hospice care, though they reflect inconsistent findings. While Black and Hispanic patients and caregivers seem to experience lower-quality care, they report overall better satisfaction and caregiver confidence than white patients and caregivers. This suggests that even when patients and caregivers experience lesser patient care, individuals do not always recognize that their care could have been better. This may be because differences are more likely to be between hospices than within a given hospice. Furthermore, Black, Hispanic, and Asian hospice patients are more likely to experience adverse outcomes, such as emergency department admission, hospitalization, and live discharge, though these differences may be related to patient preferences or other patient-specific circumstances. Studies consistently reported Asian and

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[3] Osakwe, Z. T., Arora, B. K., Peterson, M. L., Obioha, C. U., & Fleur-Calixte, R. S. (2021). Factors Associated with Home-Hospice Utilization. Home Healthc Now, 39(1), 39-47.

[4] Wang, S. Y., Aldridge, M. D., Canavan, M., Cherlin, E., & Bradley, E. (2016). Continuous Home Care Reduces Hospice Disenrollment and Hospitalization After Hospice Enrollment. J Pain Symptom Manage, 52(6), 813-821. doi:10.1016/j.jpainsymman.2016.05.031

[5] Mendieta, M., & Miller, A. (2018). Sociodemographic Characteristics and Lengths of Stay Associated with Acute Palliative Care: A 10-Year National Perspective. Am J Hosp Palliat Care, 35(12), 1512-1517.

[6] Her-Xiong, Y., & Schroepfer, T. (2018). Walking in Two Worlds: Hmong End of Life Beliefs & Rituals. J Soc Work End Life Palliat Care, 14(4), 291-314. doi:10.1080/15524256.2018.1522288

Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and other sexual orientation and identity (LGBTQ+) populations having poorer care experiences. A few small studies indicate that women, either as patients or caretakers, may have poorer experiences of care.

Pain management, a critical component of hospice care, may also have inequities in the hospice setting. Men and Black patients may have less access to pain medication, though other studies have found no difference. Some studies that focused on Hispanic and South Asian patients reported a cultural reluctance to acknowledge pain. In studies focused on caregivers, even though knowledge of or perceived barriers to pain management varied for different populations, the caregiver experience often did not.

Addressing Hospice Inequities

Studies consistently cited community engagement as essential to increasing hospice enrollment for historically excluded populations. However, effective engagement strategies vary for different populations. For example, studies suggested partnering with churches to reach Black patients, hiring Spanish-speaking staff for Hispanic patients whose primary language is Spanish, and increasing availability of local hospice providers for Indigenous Americans. For LGBTQ+ patients, studies recommended discussing gender identity and familial preferences rather than making assumptions. At the organizational level, hospices face both challenges and opportunities with respect to staffing and data collection. Hospices often struggle to recruit and retain diverse talent, and sometimes staff themselves may be subject to inequitable treatment by those for whom they care. This is particularly true for Black and LGBTQ+ staff. Diversifying leadership may provide additional support to those facing discrimination from patients. Several studies suggested that use of non-traditional care staff, such as community health workers, patient navigators, and social work students, can alleviate recruitment challenges. Use of these roles, for example, in helping patients understand hospice services, can be particularly advantageous for lower-resourced organizations.

Both studies and our experts noted insufficient data to effectively understand health inequities. This is particularly acute in LGBTQ+ communities and historically excluded racial and ethnic groups. Hospices do not collect sexual orientation or gender identity (SOGI) data, and if staff collect these data, they often do so through inference rather than a conversation with the patient to understand how they identify. Data beyond demographics, such as community-level demographic data and patient preferences, can facilitate an understanding of populations currently excluded from or receiving poorer quality hospice care. Qualitative data can help inform health equity in hospice, but experts cautioned against selection bias. Furthermore, for any data collection, validated tools may not be validated with historically excluded populations.

Few studies suggested specific measures or constructs related to health equity, though CMS asked for feedback on a health equity focused structural measure in their Fiscal Year (FY) 2023 Hospice Rule (87 FR 19442). In the months following this report, CMS will convene Technical Expert Panels (TEPs) that will reflect on the role CMS can play within its quality reporting programs to improve health equity in hospice and home health settings.

Other Recent Hospice Literature

To identify any emerging trends outside of our specific research questions, we conducted an environmental scan to identify literature related to the general quality of care in the hospice setting published in the last one to two years. Our results fell into three main categories: hospice care for dementia patients, use of new technologies in hospice, and approaches to staffing and services. One additional study explores a Health Days at Home (HDAH) measure.

Conclusion

Many studies have explored differential use of hospice care over the past seven years, with many focused on race and ethnicity. Historically excluded populations are less likely to use hospice, and often less likely to be aware of hospice care and its benefits. This is despite some evidence suggesting that Black patients are referred to hospice more often than their white counterparts. Studies consistently reported Asian and LGBTQ+ populations having poorer care experiences. Addressing equity in hospice involves community engagement, recruiting and retaining diverse staff, and expanding available data. Few studies suggested specific measures or constructs related to health equity. In the months following this report, Abt Associates will convene TEPs that will reflect on the role CMS can play within its quality reporting programs to improve health equity in the hospice and home health settings. As for other emerging trends in hospice, in the past year the literature has focused on dementia patients, technology, hospice structures, and the novel HDAH measure.

Background and Significance

Many Americans rely on hospice care for end-of-life support. In 2019, more than 1.6 million Medicare beneficiaries received hospice care, with Medicare spending $20.9 billion on hospice services (MedPAC, 2021). These services are critical to terminally ill patients. CMS continually strives to improve hospice quality and the experience of care for beneficiaries within the context of the Meaningful Measures Framework, which prioritizes high-impact quality measure areas that are meaningful to patients, their families and caregivers.

CMS anticipates expanding the Hospice Quality Reporting Program (HQRP) over the next several years to include additional meaningful quality measures that assess the quality of care provided to hospice patients. The Abt team, under contract to CMS, supports this work. The HQRP currently includes a Hospice Item Set (HIS) quality measure, claims-based quality measures, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey measures. The Abt team is also developing and testing the Hospice Outcomes and Patient Evaluation (HOPE), a draft patient assessment instrument that, when finalized in rulemaking, will support assessment-based quality measure.

The Hospice Information Gathering Reports support these efforts by reviewing available resources to inform HOPE development and related quality measures. The 2019 Information Gathering Report used stakeholder input, environmental scans, literature reviews, and focus groups to establish a candidate list of domains for HOPE inclusion. The 2020 Information Gathering Report used similar methods to explore specific areas where additional information was needed to support HOPE and quality measure development. Specifically, it addressed potential adaptation of the Integrated Palliative Outcome Scale (IPOS) for HOPE, the most clinically up-to-date signs and symptoms of a patient who is actively dying, and additional information on pain and dyspnea management to support related quality measures. The 2021 Information Gathering Report narrowly focused on hospice-specific quality measurement and data collection research related to current HOPE activities. Topics included treatment of moderate to severe pain, patient preferences, spiritual and psychosocial assessment and care, medication management, and any recent quality measurement and reporting activities in the hospice setting.

Since CMS released the last Information Gathering Report, the agency released its Framework for Health Equity which considers addressing health disparities in all of it programs, including the HQRP. In its FY 2023 Proposed Rule (87 FR 19442), CMS requested information on a structural measure intended to make hospice care more equitable. In support of CMS' health equity work, the 2022 Information Gathering Report reflects four main information gathering activities:

- **Updating our 2020 SDOH literature review:** In the 2020 Information Gathering Report, we completed a brief literature review focused on the social determinant of health that may be most applicable to the hospice setting. Those findings suggested that there are differences in pain treatment by both race and gender, that lived experience influences patient preferences, and that there is widespread geographic access to hospice services. We repeated this literature review to more narrowly focus on the hospice setting and to account for both improvements in our methods and any new material published since 2020.

- **Conducting expert interviews**: In the spring of 2022, the Information Gathering Team spoke with several experts familiar with health equity in the hospice setting. Our discussions focused on understanding how these experts are thinking about and addressing health equity in the hospice setting and informing future health equity-related information gathering activities, including our health equity literature review. Additional information on our experts and our methods, refer to Appendix I: Methods.

- **Conducting a health equity focused literature review:** As this is the first major exploration of health equity undertaken by the HQRP to date, the Abt team was broadly inclusive of items related to hospice. We categorized our results into three main themes:

    - Access to and enrollment in hospice
    - Receipt of hospice care
    - Addressing hospice inequities

- **Conducting a literature review for recent quality-related hospice activities:** To better inform HQRP measurement and reporting activities, the Abt Team gathered information on recent quality measurement and reporting activities in the hospice setting.

Given that the content of these activities overlapped significantly, the report presents integrated findings rather than summarizing results by activity. The sections of this report are as follows, largely aligning with the aforementioned themes of our health equity literature review:

- **Discussing health equity:** Here we summarize conversations with our experts in which they reflected upon how health equity should be discussed and the importance of specific language in these discussions.

- **Access to and enrollment in hospice**: Here we present findings from our literature searches and our experts about how hospice use varies among different populations. We further present information on what might contribute to that variance, including referral patterns, knowledge of hospice, and cultural, historical and environmental influences. For those who elect hospice, we also report on findings related to differences in the timing of hospice enrollment and the type of hospice in which patients enroll.

- **Receipt of hospice care**: Here we present findings from our literature searches and our experts on the experiences of those in hospice and their families and caregivers, including a dedicated section about differences in pain management.

- **Addressing hospice inequities**: Here we present findings from our literature searches and our experts on how hospice providers can address the disparities identified in earlier sections. This section includes a discussion of community engagement, organizational improvement efforts such as staffing and data collection, and next steps.

- **Other Recent Hospice Literature**: Here were present findings from our literature review focused on recent hospice publications and reports.

Methods

To address this year's information gathering topics, we searched for and reviewed both peer-reviewed and grey literature. We also conducted a limited set of expert interviews that included representatives of diversity, equity, and inclusion initiatives from hospice provider associations as well as health services researchers with relevant expertise.

For our literature reviews, we used MEDLINE/PubMed® database, supplemented with searches in Google Scholar, using pre-developed search terms (e.g., MeSH) specific to the topic. For grey literature, we established a list of well-known resources and applied key words from our topics to find relevant information. We limited our results to US articles published within the past seven years, except for the general hospice activities topic, where we used a shorter period of one year.

For our expert interviews. we created a brief, semi-structured interview guide to facilitate our discussion that included health equity focused questions on both receipt of and access to hospice care. We probed on topics such as key health equity terms and concepts, use of data, cultural gaps, hospice referral and enrollment, and increasing representative hospice staff.

Throughout the process we consulted key stakeholders to clarify the purpose or intent of the research questions and confirm expected sources of information, as needed. For more details on our methods refer to **Appendix I.** We present a summary of search results for each section in **Appendix II**, and complete literature review tables for each section in **Appendix III**.

Discussing Health Equity

CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes"[7]. A main topic area for expert interviews was how to think about and discuss health equity in the hospice setting. This both supported our development of a robust set of search terms for our literature review, and improved awareness of the importance of language as CMS works to address health inequities. Here we summarize this portion of our expert interviews.

Though not specific to the hospice setting, linguistic choices that contribute to the marginalization of some subpopulations remains prominent. Deficit-based language focuses on the absence of certain characteristics or defining others by their least desirable characteristics. Examples include "non-white" and "non-Hispanic" which implicitly reflects what the specific group or person is not, rather than what they are, which would be a strength-based approach to identifying diverse attributes. Certain phrases like "underserved" and "lack of trust in the medical system" also convey deficiency on the part of the patient, family and/or community. Often, describing a patient as "underserved" rather than "historically excluded" suggests the patient had access to services, but did not use the service or care. Reframing language in ways that do not "blame" the patient for such disparities may aid in dismantling implicit bias that can create barriers to equitable care. Similarly, describing a group of people as "lacking trust" implies that the onus is on the patient, rather than the medical system, to develop that trust and fails to recognize that for historically marginalized and excluded patient populations a lack of trust is rational and justified.

"Minority is not a race, it's a status. We should not be referring to people as minorities." – Interviewed Expert

Sometimes overly inclusive terms, even if well-intentioned, can reinforce marginalization by serving as "catch all" phrases that either become proxy terms that substitute for deficit-based language, or further obscure the groups they intend to represent. An example of the former is "minority," which is mostly, if not exclusively, used to refer to race or as a replacement for non-white. Minority is rarely, if ever, used to describe white people—even when white people are the minority (e.g., in Detroit or the District of Columbia)[8]. Moreover, terms like BIPOC, though intended to be a more inclusive term, poses their own challenges. BIPOC is used so generally that often those who use it do not recognize its intent to represent racial groups. One interviewee described an encounter with a conference presenter who, when asked who she was referring to with the term BIPOC, struggled to answer the question and ultimately replied "biracial people." In this example, BIPOC has substituted for minority, which itself has substituted for non-white. Even labels such as African American can be too broad. Not all Black people identify as African American. As one expert noted: *"My grandmother who was born in the 1800s was one step removed from enslavement, as a sharecropper, in the rural south. Her lived experiences, in the U.S. were very different experiences from my Black colleague who emigrated from the Continent of Africa by choice with an abundance of resources and formal education. My colleague also reminds me that she identifies as Nigerian American, not as African American. The cultural differences and healthcare decision-making preferences can vary widely."*

"Equity has to do with being more inclusive, and yet that's not always the case with these acronyms." – Interviewed Expert

While we recognize the significance of language and its role in health equity, much of this report compiles research conducted by others. We believe that in some cases the researchers we cite here,

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[7] https://www.cms.gov/pillar/health-equity

[8] https://www.census.gov/quickfacts/fact/table/DC,detroitcitymichigan/RHI725221

particularly those conducting interviews with their subjects, took care to represent their participants in a way that respected participant identities. However, other research, particularly research which uses aggregate data from which researchers cannot ascertain patient preferences, was not sensitive to or aware of some of the potentially stigmatizing or marginalizing language we discuss above. Where the content of this report is that of its authors we have conformed with the American Medical Association's (AMA) Advancing Health Equity: A Guide to Language Narrative and Concepts wherever possible. The AMA guidelines include, for example, white not being capitalized as other races are and using terms such as "historically excluded" rather than "underserved." However, for our descriptions of other's research we have used the terms its authors used, both to be sure we accurately represent their work and to respect instances where the authors likely accurately reflected their participants' identities. For this reason, the reader may see the same or similar populations referred to differently throughout this document (e.g., both Black and African American, or Indigenous American and American Indian), or use of language that may reinforce marginalization of certain communities.

Access to and Enrollment in Hospice

Hospice Use

Several studies reported that certain populations are less likely to use hospice care than other populations. Most of these focused on historically excluded races and ethnicities relative to white populations, though some looked at factors such as gender, education level, neighborhood characteristics, income, and region. Some of these studies have specifically explored why certain populations are less likely to use hospice care. For example, some have studied differences in awareness of hospice and its benefits among various populations. Several additional qualitative studies provided further insight into perceptions of hospice for different populations. For example, evidence suggests those who receive a palliative consultation are more likely to use hospice care. Patients who received an inpatient palliative care consultation are up to four times more likely to enroll in hospice than those who did not receive this consultation (Starr et al., 2020; Johnson et al., 2020). Some studies found no significant associations between race and hospice enrollment among patients who received a palliative care consultation (Worster et al., 2018: Starr et al., 2021). Here we discuss findings related to hospice use among different populations, and why their use patterns may differ.

Our experts also reflected on reasons why patients may not be referred to or enrolled in hospice. Many interviewees noted that clinicians typically lack training on hospice and are often uncomfortable discussing end-of-life care with patients. This is especially true if the clinician does not perceive the patient to have a caregiver. As one expert noted, many clinicians assume people of color won't be interested in hospice care, and do not have that conversation. End-of-life conversations take time and require cultural training that facilitates talking about topics that may be taboo. For example, one expert noted that patients may believe hospice is just for AIDS or cancer patients, or be hesitant to have people in their home, and overcoming these misconceptions and concerns takes time. However, these conversations about hospice are crucial for earlier referrals to hospice. Doctors that share a cultural background with their patients may find these conversations easier and may be more likely to make a hospice referral.

> "If we went to a doctor for a pain or a lump, they would not hesitate to refer you to an oncologist. However, there's a lot of hesitation around hospice referrals because the clinician doesn't understand everything that hospice entails." – Interviewed Expert

Racial and Ethnic Differences in Hospice Use

Studies that addressed hospice use by different races and ethnicities primarily reported differences between Black patients and white patients. Often, they looked at specific diagnoses or groups of diagnoses, largely cancer related. In almost all cases, Black, Hispanic, Asian, and Indigenous American patients were less like likely to use hospice care than their white counterparts. Differences in referral patterns did not seem to be a contributing factor. In fact, some studies suggested that Black patients were more likely to be referred to hospice than non-Black patients even though they seem to use hospice less. Differences in referrals were more likely across facilities than within facilities. Overall, white patients were more likely to be aware of hospice and its benefits, but the reasons patients of other races and ethnicities were less likely to use hospice were more nuanced and complex.

Hospice Use among Black Patients

Several studies reported on hospice use among patients with cancer. Two studies of Medicare patients looked at cancer generally, with one finding that Non-Hispanic Black patients who died from cancer were less likely to enroll in hospice than white patients (Koroukian et al., 2017). The other found no racial difference in hospice use for cancer patients but did find that Black patients without cancer were less likely to enroll in hospice than white patients (Samuel-Ryals et al., 2021).

Eleven additional studies looked at specific types of cancer. Black patients were less likely to enroll in or die in hospice than their white counterparts for brain metastasis (Mehanna et al., 2020; Shenker et al., 2022); ovarian cancer (Mullins et al., 2021; Taylor et al., 2017); pancreatic cancer (Paredes et al., 2021); small cell lung-cancer (Du et al., 2015), malignant glioma (Forst et al., 2018); breast cancer (Check et al., 2016); and head and neck cancer (Stephens et al., 2020). Two studies reported no racial difference in hospice use. A study of patients with cervical cancer found that place of death (hospice or hospital) did not vary between Black and white patients (Sheu et al., 2019). Another study of New Jersey Medicaid patients with breast or colorectal cancer found no racial differences in hospice use, but also found that Black patients had almost twice the odds of receiving aggressive end-of-life care than white patients (Yang et al., 2020).

All identified studies that focused on non-cancer diagnoses reported Black patients were less likely to use hospice care than their white counterparts. These included Black patients with severe acute brain injury (Jones et al., 2021), dementia (Lin et al., 2022; Oud et al., 2017), chronic obstructive pulmonary disorder (COPD) (Yaqoob et al., 2017), and those on dialysis (Foley et al., 2018). Additionally, a Florida survey of older adults found that for African American patients, an increasing number of functional disabilities was associated with decreased willingness to use hospice (Park et al., 2016).

Additional research explored potential reasons why Black patients are less likely to use hospice. Some research suggests that Black patients are more likely to want aggressive end-of-life treatment. A 2017 Kaiser Family Foundation and Economist survey found that while few Americans viewed living as long as possible as "extremely important," the share of Black respondents who felt this way (45%) was higher than that of white respondents (18%) (Hamel et al., 2017). Another survey of Black American older adults in North Carolina found they were less likely to prefer or request hospice support than their white counterparts (Cagle et al., 2016). African American decision makers for dementia patients elected life-sustaining treatments more than comfort-focused care (Hart et al., 2022). Additionally, advance directives increase the odds of a discharge to hospice, and African American patients are less likely to complete advance directives (Haines et al., 2021). One of our experts noted that in her Black American community, there may be more collective decision-making preferences. She described her mother not understanding why she would need a written advanced directive if her daughter was there to advocate on her behalf.

Other research suggests the Black patients may be unaware of hospice care and its benefits. For example, African American decision makers for dementia patients often did not use hospice fully due to a lack of information and preparedness (Hart et al., 2022), and a California-based study found Black people were less likely than non-Hispanic white peoples to be aware of hospice (Bazargan et al., 2021). Qualitative research among African American church members indicated that lack of knowledge of hospice services and spiritual beliefs were the top two contributing factors to underutilization of hospice care (Townsend et al., 2017). Further, additional interviews with African American church leaders found their congregants were unfamiliar with the terms "hospice" and "palliative care," while also harboring beliefs, perceptions, and feelings about death and dying that they had not communicated to their family members or providers. Those who had positive perceptions of hospice care were uncertain how to approach their health care providers about it (Johnson et al., 2016). A study of African American adults in Alabama's "Black belt" region found that those who were worried about stable housing or were more socially isolated were less likely to be aware of hospice care (Noh et al., 2021). Meanwhile, adults with better perceived health and higher levels of physical and social activity were more likely to have accurate knowledge of hospice. This was true for both Black adults and white adults, except for the physical activity finding which the author did not find for white patients (Noh et al., 2018).

Interestingly, recent literature suggests that Black patients are more likely to receive hospice or palliative care referrals, though this finding was not consistent across all studies and differences appear to be more common across facilities than within facilities. For example, Johnson and colleagues looked across four urban hospitals and found African American patients received more palliative care consultation referrals than both white and Hispanic patients, though there was no difference within hospitals (Johnson et al., 2020). A Chicago hospital-based study also found African American patients more likely to be referred to hospice than white patients (Sharma et al., 2015). However, a study of patients with metastatic cancer in New Jersey hospitals found Black patients were less likely to receive hospice referrals than white patients (Nicholson et al., 2022). A study of cancer centers found that minority patients were less likely to receive a hospice referral than their white counterparts, but there were no significant differences within hospitals (Wasp et al., 2020).

In a series of interviews, Rhodes and colleagues found that though African American respondents perceived hospice to be beneficial to patients and family, they also perceived cultural differences, a lack of knowledge about hospice, spiritual or religious conflicts with hospice, and mistrust in the medical system as barriers (Rhodes et al., 2017). Similarly, Dillon and Basu found that African American people's experience of discrimination or mistreatment by the healthcare system has led to a mistrust of hospice, in addition to the perception of hospice as incongruent with their cultural values and practices. Dillon and Basu also noted that African American people experience inconsistent access to medical care. This, combined with some avoiding the medical system, can lead to late diagnosis of terminal illness, thereby limiting the opportunity to receive hospice care (Dillon and Basu, 2016).

Our experts provided particularly illustrative details on why Black patients may elect not to participate in hospice even when referred. One expert illuminated how the collective experience of Black Americans has shaped their attitudes towards hospice. In addition to a medical system that has fostered distrust (e.g., the USPHS Syphilis Study at Tuskegee and J. Marion Sims' gynecological experiments on enslaved women), other cultural attitudes and beliefs affect participation. She recounted her own research on end-of-life care at an urban hospital and her inability to find a sufficient sample of Black patients to match the number of white patients who had died at that hospital, to conduct a retrospective study of the end-of-life experiences in a hospital setting. She realized that the Black American patients in that community were seeking their care at a hospital across town—a legacy that remained after decades of having been legally denied access to hospitals where only white patients received care during segregation. This translates to primary care as well. She noted that Black people may prefer aggressive treatment for illness, as they distrust the motives of those providing primary care. She further described Black Americans, particularly of older generations, relying on home remedies rather than pharmacological interventions and care, reflecting the practices they used before they had access to primary care settings. The mistrust of the medical system, influenced by historical racism, structural and systemic, makes it difficult for Black Americans to choose hospice as a culturally acceptable care option. The benefit of having a stranger provide care in the home is culturally incongruent for many Black people in the U.S. The lack of hospice enrollment and hospice utilization compounds the challenge of achieving equity, as few Black Americans elect hospice care this means there are fewer lived examples for others in the community to share, affirm and reinforce its benefits.

"The whole philosophy of hospice care is challenging for Black older adults" – Interviewed Expert

Hospice Use among Hispanic Patients

As with Black patients, research suggests that Hispanic patients are less likely to use hospice than non-Hispanic white patients. Hispanic patients with brain cancer, ovarian cancer, and malignant glioma were less likely to use hospice than white patients (Mehanna et al., 2020; Mullins et al., 2021; Taylor et al., 2017; Forst et al., 2018). However, as with Black patients, Sheu and colleagues found no variance in place of death (hospice or hospital) for Hispanic patients (Sheu et al., 2019). Non-cancer related diagnoses exhibit the same pattern. Hispanic patients with severe acute brain injury (Jones et al., 2021), dementia (Lin et al., 2022), and those on dialysis (Foley et al., 2018) were all less likely to use hospice care than their non-Hispanic white counterparts.

As with Black patients, the 2017 Kaiser Family Foundation and Economist survey found a higher share or Hispanic patients (28%) viewing living as long as possible as "extremely important," compared to 18% of white respondents (Hamel et al., 2017). As in other populations, Latino caregivers who held a strong belief that hospice care means giving up on life were less likely to consider using hospice care for their loved ones (Ko, et al., 2017). Other research finds more nuanced reasons for Hispanic patients not using hospice care. The two identified studies focused specifically on Mexican identities, and neither supported cultural barriers as the main reason these populations are less likely to use hospice care. Rising and colleagues interviewed US Mexicans with terminal cancer and found that they perceived referral to hospice as coercive in nature, unless they had an existing paternalistic view of healthcare that defers to the physician (Rising et al., 2021). Shepard and colleagues looked at Hispanic Estimate Population for Epidemiological Study of the Elderly (H-EPESE), H-EPESE Survey data, and CMS data, to determine what characteristics were associated with hospice use for Mexican Americans and found no association between hospice use and marital status, high-depressive symptoms, disability, church attendance, or seeing a physician in the last year of life. This led the authors to conclude that health system factors, rather than individual patient factors or community factors, were driving hospice use and referral variation (Shepard et al., 2022).

For referral to hospice, as with Black patients, studies were mixed. Nicholson and colleagues' study of New Jersey hospital patients with metastatic breast cancer found Hispanic patients were less likely receive hospice or palliative care referrals than white patients, while Sharma and colleague's work with Chicago hospitals found no difference in referral to hospice between Hispanic patients and white patients (Sharma et al., 2015). As mentioned previously, some studies have found no significant associations between race and hospice referral, with Worster and colleagues assessing the association between Hispanic patients and hospice referral specifically (Starr et al., 2021; Worster et al., 2018).

Qualitative studies suggest that providers are not adequately discussing end-of-life care options with Hispanic patients. A small number of interviews with caregivers of those enrolled in home hospice in rural US/Mexico border towns found that while most caregivers were informed about the patient's terminal condition, only half had a discussion with a provider about hospice (Ko and Fuentes, 2020). A small survey found Hispanic people had less knowledge of about hospice than their non-Hispanic counterparts, such as believing that only those over 65 were eligible for hospice and not knowing that hospice helps family members as well as the dying person (Carrion et al., 2015). Additional work showed Hispanic people were less likely to be aware of hospice than non-Hispanic white people (Bazargan et al., 2021).

Hospice Use among Asian Patients

Several of the studies that reported hospice use among Black and Hispanic patients also presented findings for Asian patients. Here too, white patients were more likely to use hospice than their Asian counterparts. Asian patients with brain metastasis (Mehanna et al., 2020), malignant glioma (Forst et al., 2018), severe acute brain injury (Jones et al., 2021), and those on dialysis were less like to use hospice than white patients (Foley et al., 2018). Three additional studies specified inclusion of both Asian and Pacific Islander patients in their analysis, finding for brain cancer patients, head and neck cancer patients, and cervical cancer patients these populations were less likely to die at home or in hospice than white patients (Shenker et al., 2022; Stephens et al., 2020; Sheu et al., 2019, respectively). Notably, the Asian and Pacific islander population was the only population Sheu and colleagues identified as less likely to die at home or in hospice rather than a hospital. They found no variation in place of death for Black patients, Hispanic patients, or Native American patients relative to their white counterparts (Sheu et al., 2019).

Though most studies considered Asian patients a single population, Haines and colleagues disaggregated the Asian population to provide insights within different Asian identities. This work reported that Chinese trauma patients were more likely to die in hospice than Japanese patients, Filipino patients, Indian patients, and Vietnamese patients. Korean patients were more likely to die in hospice than their Chinese counterparts (Haines et al., 2021).

As for referral to and knowledge of hospice, Shirsat and colleagues conducted a small survey of Indian Americans in Northern California to discern their knowledge of hospice. Ten percent of respondents knew someone in hospice care and ten percent were able to answer either four or five out of five questions that assessed their knowledge of hospice care. Once educated about hospice care, almost 70 percent agreed that they would consider enrolling an extremely ill family member in hospice, though 44 percent would not allow a stranger in their home, even if the stranger was with hospice (Shirsat et al., 2021). Additionally, advance directives increase the odds of a discharge to hospice, and Asian patients were less likely to complete advance directives (Haines et al., 2021). An expert we interviewed noted that for the Chinese community, older people, particularly those who do not speak English, may not have their decisions respected. For example, the patient's child may "talk over" them (intending to protect their senior patients) and older people may find it difficult to advocate for themselves in a medical setting even if the children's wishes are different than their own. Our expert described how advance care plans when an individual is still capable of talking and expressing their medical wishes can be of value, as they help clarify what the patient prefers while alleviating the decision-making burden on the children.

Hospice Use among Native American Patients

Native American populations were also less likely to use or die in hospice care than white patients in our identified studies. Studies reported this for American Indian patients and Alaska Native patients with metastatic cancer (Shiovitz et al., 2015), Native American patients with brain cancer (Shenker et al., 2022), and Native American patients on dialysis (Foley et al., 2018). Sheu and colleagues, when looking at cervical cancer patients, did not find variation in place of death between Native American patients and white patients, consistent with their findings for Black and Hispanic patients referenced in the previous section (Sheu et al., 2019).

Some qualitative studies explored potential barriers to use of hospice in Native American populations. For Great Plains Native Americans, there is not sufficient availability of hospice, resulting in long travel distances services; meanwhile, the workforce does not have adequate cultural familiarity with the Great Plains Native Americans. Historical racism and trauma further limit Great Plains Native Americans willingness to use hospice (Soltoff et al., 2022). Interviews with Elders of the Blackfeet Nations revealed that while some found "sickness should not be mentioned when it is bringing death," others felt end-of-life care was not against tradition (Colclough et al., 2019).

Hospice Use among Non-specific Patient Populations

Wherever possible, we have presented results with respect to specific racial and ethnic populations. However, many studies reported results without such specificity. These studies yielded similar results—white patients were more likely to use hospice than patients of other races or ethnicities. This held true for Medicare populations both in managed care plans and in fee-for-service Medicare (Ornstein et al., 2016; Elting et al., 2020). One study found race to be the strongest predictor of one's opinion about hospice, with white people having the most positive opinion (Lee and Cagle, 2017).

The differences are present across multiple diagnoses. White patients were more likely to use hospice than other races or ethnicities for hepatocellular carcinoma (Rice et al., 2021), gynecologic oncology (Taylor et al., 2016), and lung, esophageal, pancreatic, colon, and rectal cancers (Abbas et al., 2021). A study focused on cancer centers in the deep south found non-white cancer patients less likely to use hospice than whites (Turkman et al., 2019). Haines and colleagues found similar results for trauma patients (Haines et al., 2018).

Two studies explored reasons why some racial and ethnic groups may not use hospice. A small survey of hospice employees reported that they perceive cultural beliefs of racial and ethnic groups as barriers to their use of hospice care (Hughes and Vernon, 2020). Another study that surveyed hospice directors found that diverse populations may prefer to associate with their own cultural group, return to their home country as death approaches, or perceive hospice as "divergent to their cultural and religious beliefs or thinking" (Reese and Beckwith, 2015).

Other Sociodemographic Differences in Hospice Use

Gender

Overall, female patients were more likely than male patients to use hospice. Again, this was true for brain cancer (Mehanna et al, 2020), malignant glioma (Forst et al., 2018), COPD (Yaqoob et al., 2017), and females with cancer in the deep south (Turkman et al., 2019). A small study of female patients with metastatic breast cancer at a Boston hospital found that only one third were referred to hospice after their last hospitalization (Shin et al., 2016).

Education

Those with higher levels of education were more likely to use hospice than those with lower levels of education. Cancer patients and non-cancer patients alike were more likely to use hospice if they have higher levels of education (Ornstein et al., 2016; Koroukian et al., 2017: Forst et al., 2018). Cagle and colleagues found college education, as well as race and working in the medical industry, were predictors of hospice knowledge (Cagle et al., 2016). Higher health literacy was associated with awareness of hospice and hospice use (Noh et al., 2021; Ornstein et al., 2016). However, Ornstein and colleagues found that Medicare patients with a higher education level than their spouse were less likely to use hospice (Ornstein et al., 2016).

Socially Vulnerable Communities and Lower Income Patients

Some studies used zip-codes, the Social Vulnerability Index (SVI), or other means to determine whether place of residence was associated with hospice use. Others looked at income and its relationship with hospice use. Most studies supported higher SVI communities and patients with lower incomes being less likely to use hospice care.

Abbas and colleagues looked at patients with specific cancers (lung, esophageal, pancreatic, colon, or rectal cancers) and found that those in high SVI areas (especially non-white residents) were less likely to enroll in hospice (Abbas et al., 2021). Similarly, for patients with hepatocellular carcinoma, the probability of hospice use declined for those in areas with higher social vulnerability (Rice et al., 2021). Riggs and colleagues focused on New York patients, finding that patients who received community-based palliative care and live in a zip code with a lower share of residents living in poverty were more likely to enroll in hospice (Riggs et al., 2016). Patients in areas with low health literacy were also less likely to use hospice (Luo et al., 2021).

As for income, its influence on hospice use was mixed. While Koroukian and colleagues found higher income patients who died of cancer were more likely to enroll in hospice than those with higher incomes (Koroukian et al., 2017), Forst and colleagues found that for patients with malignant glioma, lower income predicted hospice use (Forst et al., 2018). Similarly, Dhingra and colleagues, who compared New York to the nation, found that New York's higher socioeconomic status was an independent predictor of their lower hospice use (Dhingra et al., 2022). Ornstein and colleagues also cited socioeconomic status as related to hospice use (Ornstein et al., 2016).

Region

Several of studies we have referenced previously throughout this section also found regional differences in hospice use, particularly between urban and rural areas. Rural patients were less like to enroll or die in hospice than their urban counterparts for cervical cancer (Sheu et al., 2019), malignant glioma (Forst et al., 2018), non-small cell lung cancer (Du et al., 2015), and cancer generally (Wang et al., 2016).

Fornehed and colleagues interviewed informants in rural Appalachia to better understand their attitudes towards palliative care and found that they make end of life decisions with family. The communication that encompasses family decision making for this population was both essential and complex, with education and economics influencing end-of-life decision making (Fornehed et al., 2020).

Other studies made more specific regional comparisons. Yaqoob and colleagues found that for patients with COPD, the likelihood of dying in hospice is highest in the south, at eight percent, and lowest in the Northeast, at four percent (Yaqoob et al., 2017). A Massachusetts report identified county level variation in hospice use, with particular inequities in the western part of the state, which is more rural (Massachusetts State Hospice Report, 2021).

Language

Two of our studies found that patients who spoke a primary language other than English were less likely to receive hospice referrals than their primarily English-speaking counterparts. One focused on patients with metastatic cancer in New Jersey hospitals, and the other focused on New York patients who received community-based palliative care (Nicholson et al., 2022; Riggs et al., 2016, respectively). Another study, based in Florida, generally found that non-Cuban Hispanic Floridians who were proficient in English were more willing to use hospice, but this was not true for Cuban Americans. The authors believe this may be because Cuban Americans have access to information about hospice in their native language in their communities (Park et al., 2016). Dressler and colleagues interviewed care end-of-life care providers in an Rhode Island community with a high proportion of non-English speakers and identified three key themes that contributed to language barriers in end-of-life care: structural barriers inhibiting access to interpreters, variability in how accurately end of life concepts can be translated, and the style and manner of the interpreter influencing efficacy during complex conversations. The latter two appear critical for hospice enrollment and care (Dressler et al., 2021).

Other

Additional works cited other factors related to hospice use, including facility characteristics. A higher proportion of for-profit hospices was positively associated with racial and ethnic minorities using hospice (Hughes and Vernon, 2019), and in the deep south, cancer patients seen at hospitals with inpatient palliative care beds were less likely to receive hospice care (Turkman et al., 2019). When investigating why New York State has low hospice utilization, Dhingra and colleagues found that, in addition to socioeconomic status, New York's higher number of physicians seen in the last years of life, larger number of skilled nursing facility beds, smaller number of for-profit skilled nursing facilities, and smaller number hospices relative to the nation overall independently accounted for differences in hospice utilization (Dhingra et al., 2022).

Additional factors that predicted a positive opinion of hospice include better health, greater familiarity with hospice, a high importance of pain control, the importance of fulfilling personal goals, a desire to have health-care professionals involved in one's care, and having engaged in advance care planning (Lee and Cagle, 2017). Expectations about death are also associated with hospice use (Ornstein et al, 2016).

Timing of Hospice Enrollment and Hospice Type

For patients that enroll in hospice, the time at which they enroll and the specific type of hospice services they received can vary for different populations. With respect to enrollment timing, white patients are enrolling later than other patient populations (Rice et al., 2021; Taylor et al., 2016; Turkman et al., 2019; Wallace, 2017; Ornstein et al., 2020). Rice and colleagues, who focused on patients with hepatocellular carcinoma, further found that as social vulnerability of an area increases, the likelihood of early hospice use among white patients decreases. Meanwhile, in this scenario, the likelihood of early hospice use among non-white patients increases—suggesting that though they may have less access to hospice services, Black and Latino patients may be referred to or decide to enroll earlier in hospice when it is available (Rice et al., 2021). For American Indian and Alaska Native patients, the likelihood of late hospice use was not found to be significantly different than that of their non-Hispanic counterparts (Shiovitz et al., 2015). Wallace identified other factors associated with enrollment in the Southern US. Those receiving curative treatment, referred to hospice by a family rather than a physician, and with incomes over $50,000 all took longer to enroll in hospice (Wallace, 2017). However, Haines and colleagues found that African American patients and Hispanic patients both stayed in the hospital longer than Caucasian patients when discharged to hospice—two and half days longer for Hispanic patients and nearly four days longer for African American patients (Haines et al., 2018).

A few studies examined the hospice types that different populations were likely to receive. Osakwe and colleagues used Medicare and American Community Survey data in a cross-sectional study focused on factors associated with home hospice use relative to facility-based hospice use. Hospice providers with higher proportions of women or dually eligible beneficiaries[9] were less likely to provide home hospice. For the dually eligible population, the authors believe this may reflect an institutional setting's ability to meet the higher care needs of dually enrolled patients more easily (Osakwe et al., 2021). They also analyzed the racial and ethnic makeup of a hospice's neighborhood. Specifically, higher proportions of Black patients in a hospice's neighborhood were not associated with provision of home hospice, while higher proportions of Hispanic patients in a hospice's neighborhood decreased the likelihood of the hospice providing home services (Osakwe et al., 2021). Two additional Medicare studies looked at the type of hospice care provided. One found that white patients were more likely to receive continuous home care than other races or ethnicities, and that receipt of continuous home care was associated with decreased hospice disenrollment (Wang et al., 2016). The other Medicare study found that African American patients, Hispanic patients, and female patients were more likely to receive home hospice care; white patients were more likely to receive facility-based hospice care; and for Asian patients there was no difference (Mendieta and Miller, 2018). However, a small qualitative study found that Animist and Christian Hmong elders prefer at-home care, when possible, as they felt out-of-home care facilities could not meet the spiritual and cultural needs they see as centrally integral to end-of-life care (Her-Xiong and Schroepfer, 2018).

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[9] Dually eligible beneficiaries are eligible for both Medicare and Medicaid

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The Desires of Their Hearts: The Multidisciplinary Perspectives of African Americans on End-of-Life Care in the African American Community

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Abstract

Background:

Studies have identified racial differences in advance care planning and use of hospice for care at the end of life. Multiple reasons for underuse among African American patients and their families have been proposed and deserve further exploration.

Objective:

The goal of this study was to examine perceptions of advance care planning, palliative care, and hospice among a diverse sample of African Americans with varying degrees of personal and professional experience with end-of-life care and use these responses to inform a culturally sensitive intervention to promote awareness of these options.

Methods:

Semistructured interviews and focus groups were conducted with African Americans who had varying degrees of experience and exposure to end-of-life care both personally and professionally. We conducted in-depth qualitative analyses of these interviews and focus group transcripts and determined that thematic saturation had been achieved.

Results:

Several themes emerged. Participants felt that advance care planning, palliative care, and hospice can be beneficial to African American patients and their families but identified specific barriers to completion of advance directives and hospice enrollment, including lack of knowledge, fear that these measures may hasten death or cause providers to deliver inadequate care, and perceived conflict with patients' faith and religious beliefs. Providers described approaches they use to address these barriers in their practices.

Conclusion:

Findings, which are consistent with and further elucidate those identified from previous research, will inform design of a culturally sensitive intervention to increase awareness and understanding of advance care planning, palliative care, and hospice among members of the African American community.

Keywords: African Americans, end-of-life care, advance care planning, hospice, palliative care

Introduction

African Americans have traditionally been found to complete advance directives and enroll in hospice less often than their white counterparts.[1–6] Several theories for these racial differences have been proposed, and a number of studies have examined these racial differences in completion of advance directives, hospice enrollment, perceptions of hospice quality, and even hospice revocation.[3,4,7–21] For instance, some studies suggest that an overall lack of knowledge or misunderstanding about advance care planning, palliative care, and hospice may play a role.[7,12,17] Others suggest completion of an advance directive or enrollment in hospice can be construed as losing faith in God or conflict with patients' and family members' spiritual or religious beliefs.[2,3] Mistrust in the medical system among members of the African American community has often been cited as a cause for disparities in health care that persist even at the end of life.[2,7,11] While these studies certainly add to a growing body of literature on end-of-life (EOL) care among African Americans, very little research has been done to transform these findings into interventions to enhance consideration of EOL options.

The goal of our study was to not only examine perceptions of advance care planning, palliative care, and hospice from the perspectives of African American providers, caregivers, and patients but also to use our findings to inform development of a culturally sensitive intervention that will increase awareness of these options among a segment of the population that has historically underutilized them. We believe that this study is one of a few that uses qualitative methods to examine racial differences in EOL care from a multidimensional view of African Americans—those who have provided EOL care, are recipients of EOL care themselves (as patients or caregivers), and those who have done both.

Methods

We conducted semistructured interviews with an African American hospice and palliative medicine physician, an African American palliative care nurse practitioner, an African American minister who had also served as a hospital and hospice chaplain, 2 African American caregivers of hospice patients, and a current African American hospice patient to gauge their perceptions of EOL care, barriers to EOL care, and specific strategies the providers use to counteract those barriers among members of the African American community. To ensure that we examined perceptions of EOL care from diverse group, we followed these interviews with focus groups that included community-dwelling African Americans who received care at one of our University-affiliated clinics or hospitals, served as a caregiver for someone who received care at one of our University-affiliated clinics or hospitals, or were recommended by others to participate based on their personal experiences with EOL care. We followed the approach of purposive sampling among a diverse set of persons who had experience with the provision and/or receipt of palliative care, hospice care, or provision of counsel to seriously or terminally ill persons and their families. All respondents gave verbal consent to participate per UT Southwestern Medical Center Institutional Review Board-approved protocol.

Question Guide

The interview templates were made up of 18 questions that explored respondents' personal and/or professional experiences with EOL care or the care of a seriously ill loved one. Participants were asked about their perspectives on advance care planning, palliative care, and hospice care in the African American community and to identify what they believed were barriers to completion of advance directives and hospice enrollment among members of the African American community. Respondents were also asked how they would counsel a patient, congregant (if applicable), friend, or loved one about completion of an advance directive or enrollment in hospice. Similarly, focus group templates were made up of questions that expounded on participants' experiences with EOL care, their knowledge of treatment options (i.e., advance care planning, palliative care, and hospice), and ways that barriers to participation in these treatment plans could be addressed. The semistructured interview and focus group templates were developed with input from all members of the study team.

Data Collection and Data Coding

The study period was from November 18, 2014, to October 2, 2015. Interviews and focus groups were transcribed, and they were coded by 2 individuals (Ramona L. Rhodes and Bryan Elwood). At periodic intervals, data were discussed, and the coding scheme was refined. Disagreements were resolved by discussion, and although a third individual was available (Simon C. Lee) to resolve any disagreements, the 2 coders were able to come to consensus on the coding scheme. The codes identified fell under the categories of benefits and barriers to completion of advance care planning and hospice enrollment, strategies to increase awareness of options for EOL care, and personal and professional experiences with EOL care in the African American community. Participants were enrolled until thematic saturation was reached, and no additional emerging themes were identified.

Results

Semistructured Interview Participants

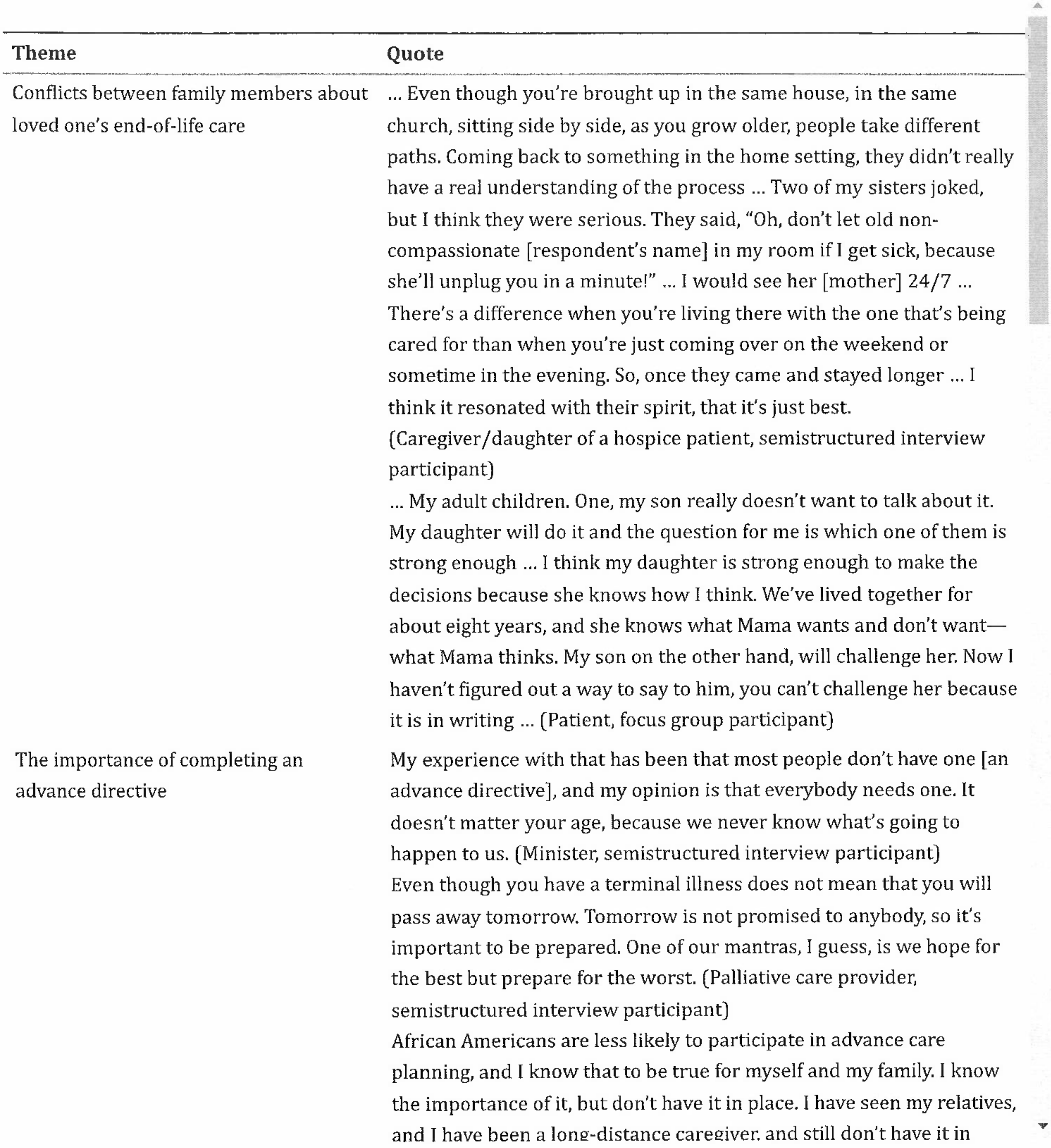
Of the 17 participants, 6 completed semistructured interviews. The interview participants consisted of a convenience sample of women who self-identified as African American and had varying degrees of involvement with hospice and/or palliative care: a board-certified hospice and palliative care physician who served as medical director for a local hospice agency, a palliative care nurse practitioner who worked for a local safety-net hospital system, a minister who had served as a church pastor and hospice/hospital chaplain, 2 caregivers of patients (with advanced dementia and cancer diagnoses) who received hospice care, and 1 current hospice patient. The hospice and palliative medicine providers and ministers who were interviewed had personal experience with the care of a loved one who was either terminally or seriously ill in addition to their professional work. The interviews ranged from 25 to 64 minutes in duration, were video recorded for potential use in development of a culturally sensitive educational intervention for EOL care for African Americans, and transcribed for analysis.

Focus Group Participants

Eleven participants participated in 1 of 2 focus groups. Four participants (2 men and 2 women) were members of our UT Southwestern Center for Patient Centered Outcomes Research (PCOR) Community Advisory Panel (CAP), a panel of community members with a connection to Parkland, our local safety-net hospital, as patients or family members of patients who receive care there. Two participants were African American men who served as ministers in local churches with predominantly African American congregations. The remaining 5 participants were women who received care from one of our university-affiliated clinics, served as caregiver for someone who received care from one of our university-affiliated clinics, or were recommended based on their personal experiences with EOL care. The focus groups lasted 90 minutes and were audio-recorded and transcribed for analysis. Selected themes and additional quotations from the semistructured interviews and focus groups are included in Table 1.

Table 1.

Selected Themes and Additional Quotes: Perspectives on Advance Care Planning and End-of-Life Care in the African American Community.



Theme	Quote
Conflicts between family members about loved one's end-of-life care	… Even though you're brought up in the same house, in the same church, sitting side by side, as you grow older, people take different paths. Coming back to something in the home setting, they didn't really have a real understanding of the process … Two of my sisters joked, but I think they were serious. They said, "Oh, don't let old non-compassionate [respondent's name] in my room if I get sick, because she'll unplug you in a minute!" … I would see her [mother] 24/7 … There's a difference when you're living there with the one that's being cared for than when you're just coming over on the weekend or sometime in the evening. So, once they came and stayed longer … I think it resonated with their spirit, that it's just best. (Caregiver/daughter of a hospice patient, semistructured interview participant) … My adult children. One, my son really doesn't want to talk about it. My daughter will do it and the question for me is which one of them is strong enough … I think my daughter is strong enough to make the decisions because she knows how I think. We've lived together for about eight years, and she knows what Mama wants and don't want—what Mama thinks. My son on the other hand, will challenge her. Now I haven't figured out a way to say to him, you can't challenge her because it is in writing … (Patient, focus group participant)
The importance of completing an advance directive	My experience with that has been that most people don't have one [an advance directive], and my opinion is that everybody needs one. It doesn't matter your age, because we never know what's going to happen to us. (Minister, semistructured interview participant) Even though you have a terminal illness does not mean that you will pass away tomorrow. Tomorrow is not promised to anybody, so it's important to be prepared. One of our mantras, I guess, is we hope for the best but prepare for the worst. (Palliative care provider, semistructured interview participant) African Americans are less likely to participate in advance care planning, and I know that to be true for myself and my family. I know the importance of it, but don't have it in place. I have seen my relatives, and I have been a long-distance caregiver, and still don't have it in

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	was brought up in the church. My brother's a minister. My brother-in-law is a pastor and here we are all looking at each other like what are we going to do because these types of preemptive steps weren't taken and a lot of this had to do with, unfortunately, my mother held a block up. She would say, "Oh, let the Lord have His way. Oh, I believe the Lord's gonna heal your father. Oh just have faith. Oh ... " and it's heart wrenching now because we ... like I said, it's been so difficult to get care for my father and now with my mother going through her challenges, it's like she just did not want to come to grips with the fact that she was getting older and that she could not keep on the way that she's been going. (Minister/caregiver/focus group participant)
Strategies to overcome barriers to advance directive completion	I tell patients, it's not a matter of ... you fill out this paperwork and we're no longer going to do anything for you. We want to do right by you, so I think it's very important for you to address this—notonlyforyourselfbutforyourfamily. (Palliativecareprovider,semistructuredinterview participant)
The benefits of palliative care	*The Interdisciplinary Approach.* We have chaplains. We have social workers, so we don't only focus on your disease process. We focus on you, your family, your spirituality, your emotional wellbeing ... it's kind of the whole, instead of just, you have this disease and that's all we're going to talk about. (Palliative care provider, semistructured interview participant)
The benefits of hospice	*Some Relief of Caregiver Burden.* My experience with hospice was so wonderful. The people were so nice and compassionate. It's a wonderful program. And you know what? It was for the patient, but it was also for the caregiver, too ... It took the actual day-to-day work off of me—that was their responsibility. They told me it was theirs and I did not try to hold on to it. (Caregiver/daughter of a hospice patient, semistructured interview participant) *Compassionate Care.* I felt something that I didn't expect to feel, and that was just so much admiration and heart for the providers ... for somebody to have the kind of heart to choose to deal every day, all their career with people who are at the end, that takes a special type of person. (CAP member/focus group participant)
Barriers to hospice enrollment	*A loss of faith in God.* I think again, it goes back to the faith thing. That if

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Barriers to hospice enrollment	*A loss of faith in God.* I think again, it goes back to the faith thing. That if I go on hospice does that mean I'm losing my faith in God, that I'm saying that God can't heal me, or God won't heal me, because I've gone on hospice? I've given up, and so God is not going to act on my behalf for sure because I'm not trusting God enough to just heal me? Again, God is going to do what God's going to do. (Minister) *Fear of death/losing a loved one.* I have a strong faith because I actually believe that all things are possible. But there are some times when we will talk our faith and not walk our faith. It's not that you're giving up on God, but what I don't think they realize is that when they pray for a healing, death is a healing … It's not the healing that you might want, but as sure as we're born we're going to die. And we're healed from the troubles of this world … So, I think their fear is not so much that they've given up on God, it's that they don't see death as a healing, and that they're loved ones are truly, truly in a better place. (Caregiver/daughter of a hospice patient, semistructured interview participant) *Mistrust in the Medical System.* I think enrolling African American patients in hospice is difficult, and the reason why is because I think patients equate hospice with death. And I also think that they feel that once we enroll them in hospice, we've given up, no one cares, and no one is going to check on them, focus on them, and we're just saying, "You know what? You've got this disease process that you may not last long with and we're just done" … It's important for patients to understand that we still care. (Palliative care provider, semistructured interview participant)
Strategies to overcome perceived	*Continued use of Prayer Throughout the Process.* Well I'm a firm

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	that she was getting older and that she could not keep on the way that she's been going. (Minister/caregiver/focus group participant)
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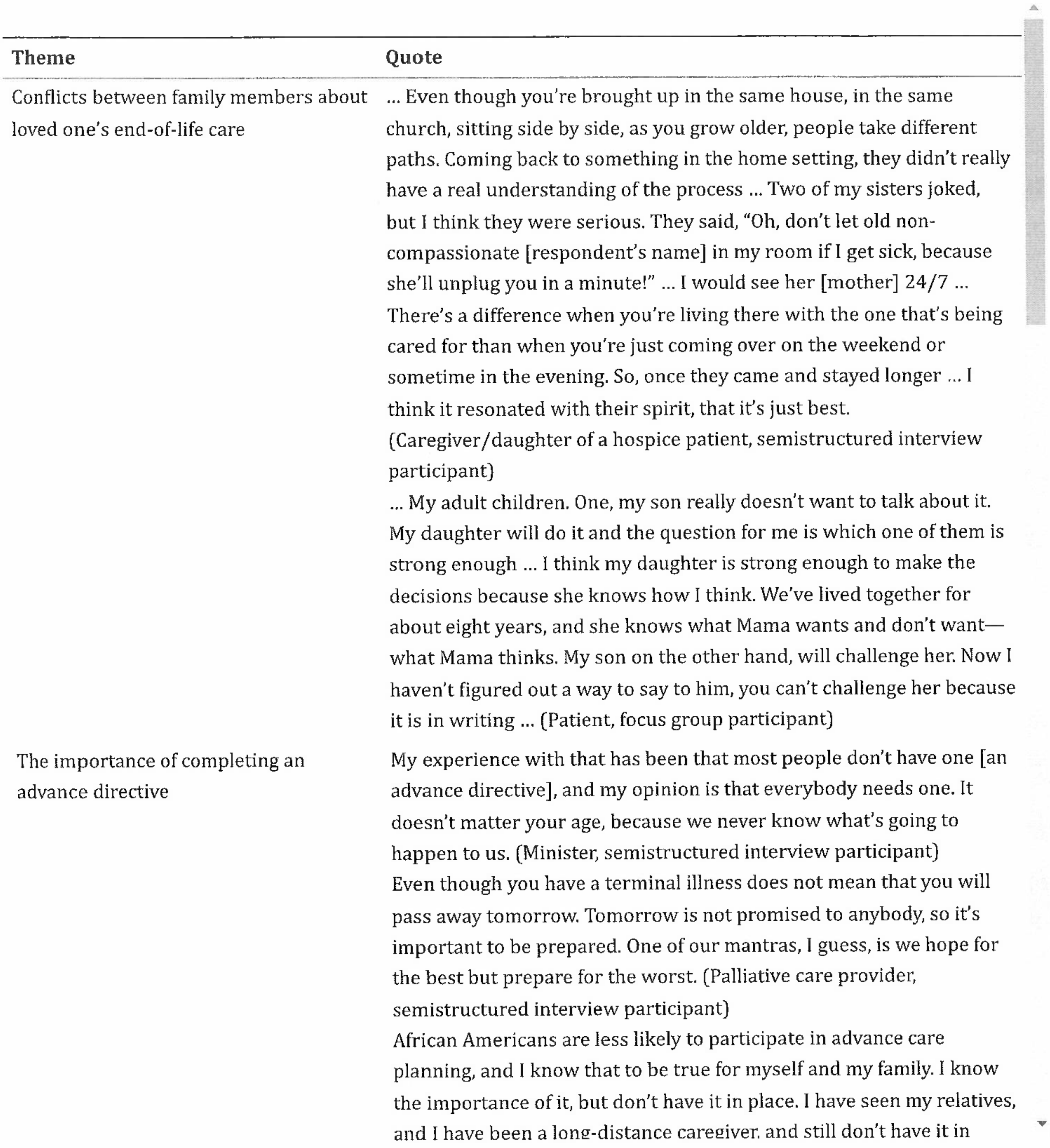
Selected Themes and Additional Quotes: Perspectives on Advance Care Planning and End-of-Life Care in the African American Community.

The importance of completing an advance directive	My experience with that has been that most people don't have one [an advance directive], and my opinion is that everybody needs one. It doesn't matter your age, because we never know what's going to happen to us. (Minister, semistructured interview participant) Even though you have a terminal illness does not mean that you will pass away tomorrow. Tomorrow is not promised to anybody, so it's important to be prepared. One of our mantras, I guess, is we hope for the best but prepare for the worst. (Palliative care provider, semistructured interview participant) African Americans are less likely to participate in advance care planning, and I know that to be true for myself and my family. I know the importance of it, but don't have it in place. I have seen my relatives, and I have been a long-distance caregiver, and still don't have it in place. So you know, it's time. We can't wait any longer. You need to do this. (Patient/caregiver focus group participant) ... And I'm actually going through this right now with my father. My father has dementia. My mother is his primary caregiver. My mother suffered a TIA so she was in the hospital, and we found out that she had multiple strokes over the years and she didn't tell us. So now my mother can't take care of my father and my father, because he has dementia, is incapable of telling us anything or giving us any information to take care of him. My father was a deacon in the church. I was brought up in the church. My brother's a minister. My brother-in-law is a pastor and here we are all looking at each other like what are we going to do because these types of preemptive steps weren't taken and a lot of this had to do with, unfortunately, my mother held a block up. She would say, "Oh, let the Lord have His way. Oh, I believe the Lord's gonna heal your father. Oh just have faith. Oh ... " and it's heart wrenching now because we ... like I said, it's been so difficult to get care for my father and now with my mother going through her challenges, it's like she just did not want to come to grips with the fact that she was getting older and that she could not keep on the way that she's been going. (Minister/caregiver/focus group participant)
Strategies to overcome barriers to advance directive completion	I tell patients, it's not a matter of ... you fill out this paperwork and we're no longer going to do anything for you. We want to do right by

Abbreviation: CAP, Community Advisory Panel.

Table 1.

Selected Themes and Additional Quotes: Perspectives on Advance Care Planning and End-of-Life Care in the African American Community.



Theme	Quote
Conflicts between family members about loved one's end-of-life care	... Even though you're brought up in the same house, in the same church, sitting side by side, as you grow older, people take different paths. Coming back to something in the home setting, they didn't really have a real understanding of the process ... Two of my sisters joked, but I think they were serious. They said, "Oh, don't let old non-compassionate [respondent's name] in my room if I get sick, because she'll unplug you in a minute!" ... I would see her [mother] 24/7 ... There's a difference when you're living there with the one that's being cared for than when you're just coming over on the weekend or sometime in the evening. So, once they came and stayed longer ... I think it resonated with their spirit, that it's just best. (Caregiver/daughter of a hospice patient, semistructured interview participant) ... My adult children. One, my son really doesn't want to talk about it. My daughter will do it and the question for me is which one of them is strong enough ... I think my daughter is strong enough to make the decisions because she knows how I think. We've lived together for about eight years, and she knows what Mama wants and don't want—what Mama thinks. My son on the other hand, will challenge her. Now I haven't figured out a way to say to him, you can't challenge her because it is in writing ... (Patient, focus group participant)
The importance of completing an advance directive	My experience with that has been that most people don't have one [an advance directive], and my opinion is that everybody needs one. It doesn't matter your age, because we never know what's going to happen to us. (Minister, semistructured interview participant) Even though you have a terminal illness does not mean that you will pass away tomorrow. Tomorrow is not promised to anybody, so it's important to be prepared. One of our mantras, I guess, is we hope for the best but prepare for the worst. (Palliative care provider, semistructured interview participant) African Americans are less likely to participate in advance care planning, and I know that to be true for myself and my family. I know the importance of it, but don't have it in place. I have seen my relatives, and I have been a long-distance caregiver, and still don't have it in

Abbreviation: CAP, Community Advisory Panel.

Themes

Sharing Personal Experiences With EOL Care

The health care providers, ministers, and caregivers who were interviewed shared their personal experiences with EOL care. They admitted that making decisions and being involved in EOL discussions about their own loved ones was difficult, but they understood the importance of focusing on their loved ones' experiences instead of their own feelings about their loved ones' care and, ultimately, their passing. A minister, who participated in one of the semistructured interviews, described her feelings about her mother's care at the end of life in the following way:

> *When my mom died, I didn't want her to go, but she was not in good shape. She was in a lot of pain, and she had been praying for at least three years, that she would say, "Lord, I'm tired. I just want to go home. I'm ready to go home." At first I couldn't pray that prayer with her, because, I was like, "No, my mom. I don't want my mom to go." But I saw her about three months before she died, and she was in so much pain. At that point, I could say, "God, give her the desires of her heart, because I don't want to see my mother laying there suffering like that." It just felt, for me, to continue to hold on ... just felt selfish. I miss her, but am so happy for her. I am.*

The respondents also described conflicts experienced with other family members—particularly those who were not as closely involved in caregiving and preferred aggressive treatment at the end of their loved one's life but stated that their family members eventually became more accepting of the process over time.

The Importance of Completing an Advance Directive

Several participants in the interviews and focus groups felt that having an advance directive was important and emphasized that everyone should have one regardless of current health status or age. Some felt that having an advance directive in place would take pressure off of family members to make decisions regarding care of the seriously ill. A caregiver of a hospice patient and semistructured interview participant said:

> *I think that it's important for the purpose of, if nothing else, but keeping down a lot of anxiety. If you've got siblings ... or other family members who come in because they think you don't make the right decision or you're not taking care of their loved one ... you can always present them with a copy, and say, this is what we discussed and this is what Momma wants ... They don't have to take your word for it. Here it is, right here.*

Barriers to Completion of Advance Care Planning Among African Americans

Respondents identified certain barriers to completion of advance care planning among members of the African American community. Some felt that a lack of understanding about what advance care planning is and should include (ie, completion of a living will or do-not-resuscitate order, identification of a medical power of attorney, etc) was a barrier. They said lack of knowledge about advance directives created a fear of completing them. Others felt that some would think that completion of an advance directive or other document would mean that health-care providers would no longer care for them or it would hasten death. A hospice provider said, "That's the other reason why people just don't want to sign advance directives. It's like you're saying, 'Well, bring it [death] on."

Faith in God was also perceived as a barrier to advance care planning. A minister said:

> *... I think faith is a factor as well. I think in our tradition God has the first word and the last word, and I think there are some who feel that using an advance directive takes something away from God, that it makes God not the all-powerful being that we know God to be or expect God to be. And so I think we tend to shy away from it ... because we feel that it somehow goes against our faith, you know. It's not a matter of losing faith ... we're all going to die at some point.... Our Christian faith teaches us that there is a life beyond this life ... and our hope, our belief, is that the life beyond this life is a better life.*

Another minister and focus group participant said:

> *There is nothing that I can do in my human capacity that will limit God. God is limitless. God is omnipotent, an all-powerful, allknowing God. If He decides that He wants to heal me, whether I decide to have a directive or not, you know, that's His will ... I can still plan and put things in order and believe God at the same time. It doesn't mean that I'm giving up.*

The Benefits of Palliative Care

The respondents who were palliative care providers realized that many patients and families are not familiar with the concept of palliative care, and other participants acknowledged little understanding of the concept of palliative care. When asked how they would describe palliative care to patients and families, the providers emphasized that palliative care is provided by an interdisciplinary team that will not only treat symptoms related to underlying illness but also provide much needed support during a very challenging time. A palliative medicine provider said:

> *... A lot of times we ignore the fact that the patient is a person—a person with feelings. A person with symptoms that could be, you know, pain, anxiety, and depression. There could be physical issues, psychosocial and spiritual issues that need to be addressed at this time ... I'll be there to help them navigate through the diagnosis as well as help with working on symptoms and helping them be comfortable.*

Both providers also felt that it was important for patients and families to know that patients who receive palliative care can continue to get their usual care, and in some instances, palliative care can be provided in the inpatient and outpatient setting.

The Benefits of Hospice

All respondents said hospice was beneficial to patients who are terminally ill. Providers who had their own experiences with hospice described those experiences. A minister and interviewee reported that, "Hospice is a wonderful service, and for me a wonderful ministry for patients who are facing the end of life. For the patient and for the family—the care that patients and families received from hospice staff is just priceless. It really is." A current hospice patient also described her hospice experience when she said, "Well there is some very sweet people that comes around, is helpful, want to be helpful ... I told them I could do it, but they still here to help me, and I love that. I love the company, the nurses that come by ... they keep me comfortable at home."

Perceived Barriers to Hospice Enrollment Among African Americans

Participants identified several different barriers to hospice enrollment, including cultural differences, conflicts with spirituality and religious preferences, overall lack of knowledge about what hospice entails, and mistrust in the medical system. A hospice provider explained perceived barriers to hospice enrollment among African Americans in this way.

> *I would say that there are many reasons. There are very strong cultural factors ... African Americans can be very spiritual and really place a lot of importance on spiritual and religious issues. And so, you will find African Americans worried about hospice, meaning that they're giving up on hope or giving up on faith or believing in God ... Another situation that I've encountered is just not having enough information about what hospice really is ... You know, sometimes people think that there's some kind of hospice location where their loved one won't get personal care. Another issue that I've encountered, which has been widely described in the medical literature, is mistrust of the medical care system. I've seen it over and over again, where some African American patients feel that because of their knowledge of things that have happened in history that they may be getting less than adequate care, and that's why they're referred to hospice.*

Strategies to Overcome Perceived Barriers

When asked how they would discuss hospice with members of the African American community, several approaches were mentioned. For instance, to counteract the belief that hospice means giving up on faith, caregivers who had experience with hospice mentioned the power of prayer even after enrolling in hospice. One caregiver suggested that patients and families "go and pray with the Lord about the journey they are about to take." A minister mentioned that healing can still occur for patients on hospice, just not healing in the traditional sense.

> *I think that God heals us all, but God doesn't always cure us. To me, to be healed is to live as fully as you can in the present with whatever capabilities you have. That person who is living a life as fully as they can with whatever capacities they have, to me, is a healed person. God is with us and God is able to bring good out of whatever limitations we have a human beings.*

Another minister and focus group participant mentioned that hospice agencies must provide education about the purpose of hospice.

> *They must communicate what they're all about and attempt to debunk the preconceived notions that are out there about hospice care and effectively communicate what the objective of hospice care is ... I think for me, too long hospice care has been kind of kept in a box. We take a person through all these processes, treatments and all types of rehabilitation—all types of other treatment and then when we come to what appears to be the edge, we get hospice.*

Participants also mentioned that patients and families can and should continue to seek comfort from their pastor and church members and that hospice chaplains can offer much-needed additional support. They felt that if patients had this continued link with their spiritual community, and their community was also included in the process, patients and families may be more accepting of hospice care.

Respondents indicated that medical mistrust plays a role in completion of advance directives and hospice enrollment. They commented that for patients and families, EOL decision making requires time and the establishment of trust between patients, families, and providers. It also requires providers to "respect where people are" in the decision-making process and speak to them in a language that they can understand. The respondents also realized that though culture and shared experiences certainly play a role in disparities in care, learning about each individual patient is equally as important. They suggested that providers integrate religious and cultural beliefs into the care plan while maintaining that each patient has his or her own individual preferences.

Discussion

Overall, the participants expressed the belief that advance care planning is important, can help to limit conflicts among family members, and alleviate pressures to make "the right" decision for care at the end of life. Palliative care providers indicated the importance of consultation with palliative care team members as valuable opportunities to help patients understand differences between curative treatment and symptom relief with respect to their specific course of the disease. They were aware that there is a lack of knowledge about palliative care among patients and families and felt that increased education about all spectrums of care for the chronically and terminally ill should be enhanced. This was confirmed by our focus group participants. They expressed a keen interest in learning more about palliative care and what it entails. All participants believed that hospice was helpful but understood why there are barriers to enrollment among members of the African American community.

The barriers to completion of advance directives and hospice enrollment identified among those interviewed are commonly cited in the literature as significant barriers to these services among members of the African American community.[2,3,7,11,12,17] They include medical mistrust, conflict with spirituality, and lack of knowledge. Both providers and recipients of EOL care mentioned possible ways to overcome barriers in this population. Respondents felt that it was extremely important to establish and build trust with patients and their families, avoid use of medical jargon, and allow them time to make informed decisions about their care. They recommended continued prayer, inclusion of the patient's spiritual community throughout the process, and establishment of connections with faith-based communities so that education can be provided about these important care options. Finally, they noted that whatever decision patients and family members make about EOL care should be accepted and respected.

While the goal of this study was to examine perspectives on EOL care from the viewpoints of a diverse group of African Americans, the semistructured interviews also serve an additional purpose. These video-recorded interviews have formed the basis of development of an educational intervention that will be tested among African Americans who receive their care at a local safety-net hospital. We have used the rich commentary from the semistructured interviews to design a culturally sensitive intervention that we hope will make seriously ill African American patients and their families aware of their options for advance care planning, management of pain and other symptoms, and EOL care—a research agenda that has been limited in scope thus far. Additionally, we plan to test the feasibility, acceptability, and efficacy of this intervention and if successful, disseminate this program to other sites and settings.

There are certain limitations that should be taken into account with regard to this study. This formative research was limited to a sample of African Americans who have had some experience EOL care in one geographic area. The interviews and focus group responses are not necessarily reflective of all African American patients, caregivers, and providers of palliative care or hospice. Findings noted in this qualitative research, however, are in step with findings from other studies that have examined EOL care for African Americans. Furthermore, our study examines perceptions of EOL care from a multidisciplinary group of providers, patients, ministers, and caregivers who have had varying degrees of personal and/or professional experiences in EOL care in a variety of care settings.

The participants in these interviews and focus groups gave insight into their lives and practices and shared their personal and professional experiences with EOL care. They further illuminated the importance of advance care planning and the benefits of palliative care and hospice. Ultimately, partnerships should be created among health care, community, and faith-based organizations so that education about these important topic areas can be more widely dispersed. This research takes the important step of moving from identification of racial differences in EOL care to the design and implementation of interventions to reduce those differences so that African American patients and their families can make decisions about their care at the end of life that are truly informed.

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Footnotes

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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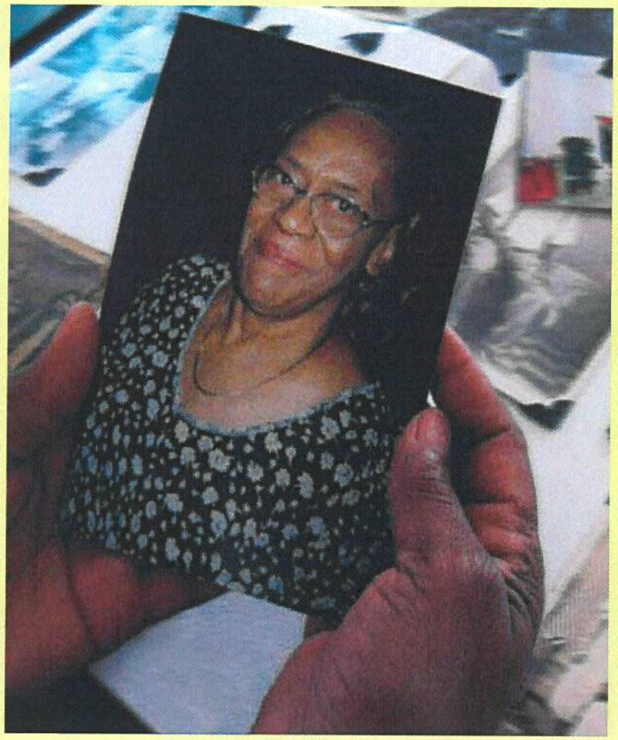
What Y'all Gon' Do With Me?



The African-American Spiritual and Ethical Guide to End of Life Care

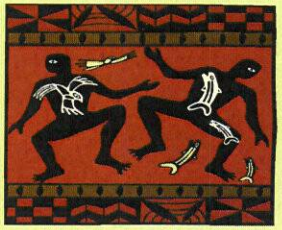
By Gloria Thomas Anderson, MSW

Purpose

- To provide a consumer friendly guide on end of life issues for African-American population.

- To address the unique cultural, historical and spiritual values in the decision-making process from a strengths perspective of self empowerment.

Purpose - continued



- To increase the participation of African-Americans in the decision-making process of End of Life care.
- To offer a proactive tool that can facilitate and educate this population on important End of Life issues.

Why This Approach?

- ☐ Racial disparity in health care (Institute of Medicine, 2002)
- ☐ Mistrust of doctors and proposed treatment options
- ☐ Miscommunication
- ☐ Cultural competency concerns

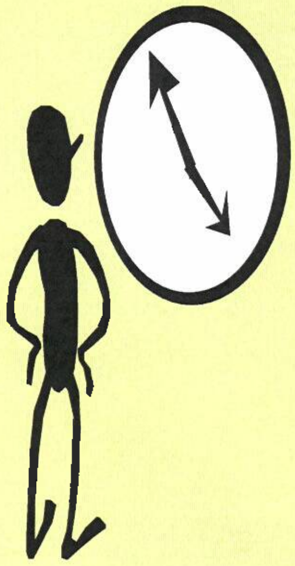
Why the Historical Mistrust in Healthcare?

- Racism in medicine has always existed and is deeply embedded in institutions, policies and personal mindsets.
  - The Tuskegee syphilis study (Chadwick, 1997)
  - Less use of cardiac procedures, reduced access to renal transplants, and fewer surgeries for lung cancer (Peterson,et al., 1997; Chen, et al.,2001; Bach, et al.,1999; Schulman, et al., 1999, Ayanian, et.al.,1999)

Barriers to Appropriate and Equitable Health Care and Everyday of Life

- Biases
- Prejudice
- Stereotyping
- Discrimination
- Fear
- Ignorance
- Deception

Isn’t It Time To Advocate For Real Change?



“We must discern not only the poors’ lives, their living conditions, and social connections, but their mistrust of the health care system. We must learn about their cultural, spiritual and religious values. And we must come to appreciate how social, cultural, ethnic and racial experience holds sway over their understanding and response to illness, suffering, dying, and death.”

- David Wendell Moller, Ph.D.

Director of Sirridge Office of Medical Humanities, School of Medicine, UMKC

Legislative, Policy and Organizational Efforts

- Patient Self Determination Act of 1991
- Healthy People 2010 Agenda
- Initiative to Improve Palliative and End-of-Life Care in the African-American Community (Crawley, Payne, Bolden, Washington, & Williams, 2000)

- The National Medical Association (NMA)
- Institute of Medicine (IOM)
- Pew Research Center (www.people-press.org

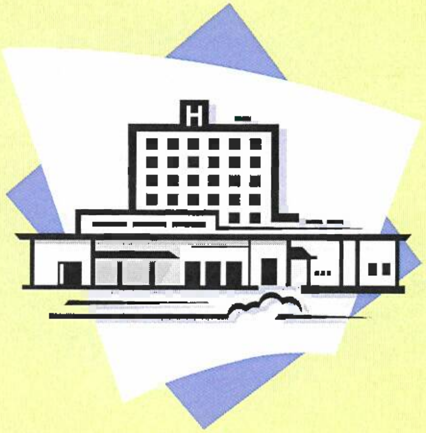
- Commission on Health Disparities and the Impact of Racism on African-American Health Status

Social and Economic Factors Affect African-American EOL Decisions

1865-1872

1965-1975

(Hood, 2001)

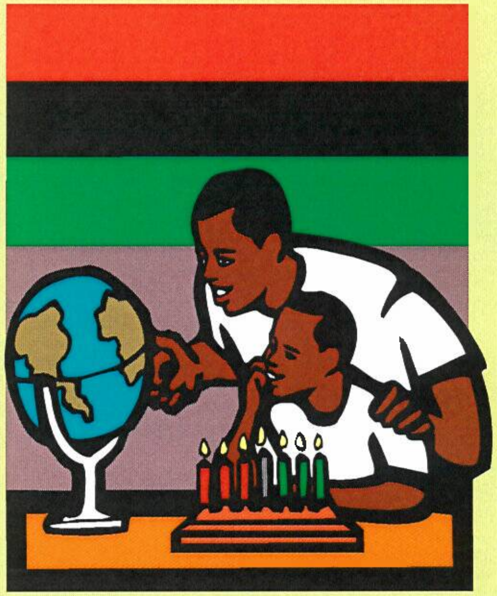


Engrained
Institutionalized
Racism

The
imbalance
remains…

Historical Perspective-Spirituality

- West African backgrounds
- Slavery
- A Spiritual People
- The Church



Religion vs. Spirituality

- Religion—a particular set of institutionalized belief systems and standards that provide direction and instruction for one’s life

- Spirituality—a personal expression and/or connectedness with something or someone greater than one’s self that gives meaning and purpose to one’s life.

Religion, Spirituality and the Church

--50% of African Americans say they are "born again" or evangelical Protestants

(Pew Research Center, 2003)

--Religion and spiritual beliefs have been attributed to influencing the treatment preferences of African Americans in the face of illness (Johnson, Elbert-Avila & Tulsky, 2005)

Recurrent Themes in African American Spiritual Beliefs

- A source of comfort, coping and support
- An effective way to influence healing
- God is responsible for physical and spiritual healing
- The doctor is God's instrument

(Johnson,Elbert-Avila & Tulsky, 2005)

Universal Spiritual Values—
Issues of the Spirit

- Why me?
- What will happen to me?
- What has my life meant?

Spirituality- A Sustaining Force

- 63% of people believed it is good for doctors to talk to patients about their *spiritual* beliefs. (Last Acts Committee, 2002)
- Many African-Americans resort back to their religious and cultural beliefs at the end of life. (Ersek, Kawaga-Singer, Barnes, Blackhall, & Koenig, 1998)

Some African-American Traditional Southern-Based Cultural Values-

- Hard to label/categorize
- High value on friends and non-family relationships
- Family centered approach ("village" concept)
- Family heritage, belief system and traditions

Some Southern African-American Generational and Family Values

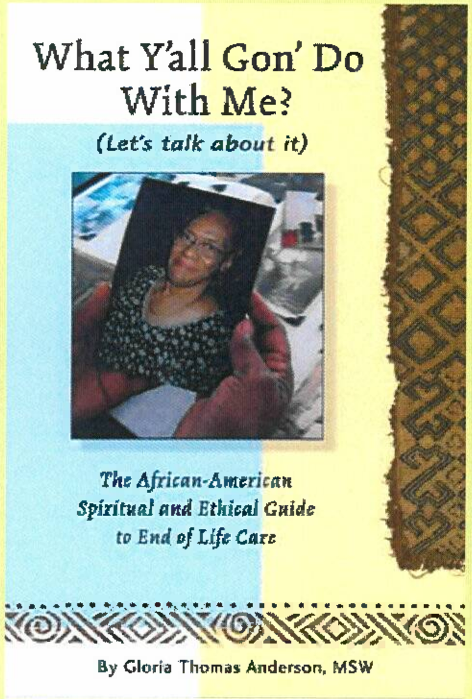
- ☐ Sacrificing one's own needs (Born, et.al, 2004)
- ☐ Family directed care
- ☐ Relying on their spirituality and faith
- ☐ Having someone to listen and care
- ☐ Relief from physical and financial stress
- ☐ Focusing on "life" rather than "death" (Blackhall, Frank, & Murphy,1999)

The End of Life Guide and Ethics

- To illustrate respectfulness and dignity to the patient’s autonomy
- To include the critical conflicting moral and legal mandates
- To provide pertinent information and resources that could benefit the African American population

The African-American Spiritual and Ethical Guide to End of Life Care

Have you gotten <u>your</u> house in order?



What Y'all Gon' Do With Me?

(Let's talk about it)

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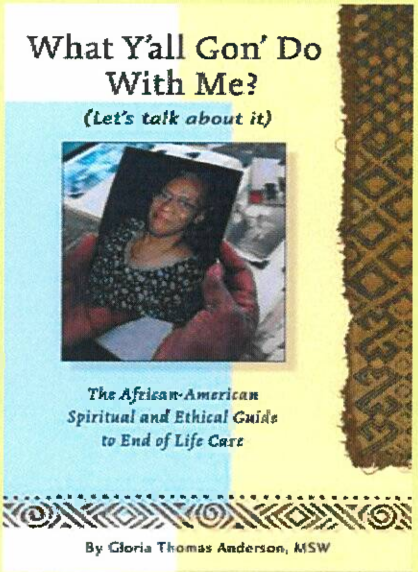
14 Important End of Life Issues You Want and Need To Know About

The African-American Spiritual and Ethical Guide to End of Life Care

- Taking Control of Your Life and Health
- Gettin' Your House in Order
- More to Life than Being "Alive"



What Y'all Gon' Do
With Me?
(Let's talk about it)

*The African-American
Spiritual and Ethical Guide
to End of Life Care*

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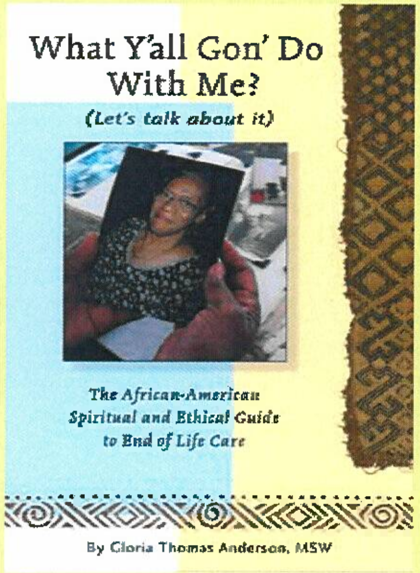
The African-American Spiritual and Ethical Guide to End of Life Care

- The "F" Factor—Family, Friends and Foe
- The Healing Balm of Forgiveness
- Coping and Hoping—A Spiritual Journey



What Y'all Gon' Do With Me?

(Let's talk about it)

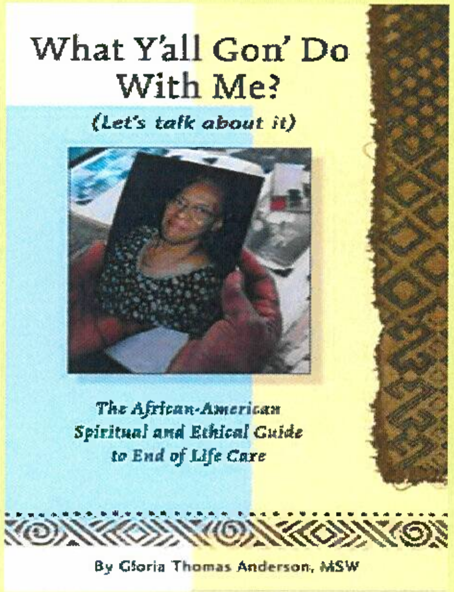
The African-American Spiritual and Ethical Guide to End of Life Care

By Gloria Thomas Anderson, MSW

- What's All This "End of Life" Stuff About?

The African-American Spiritual and Ethical Guide to End of Life Care

- Advance Directive Choices
- Planning for Emergency Situations, Even For People Who Are Not Terminally Ill
- 5 Important Things To Do



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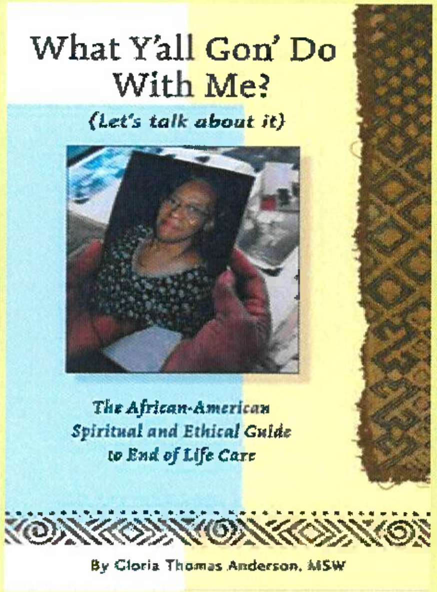
- Puttin' On My Traveling Shoes
- Comforting Words
- Your Legacy...Your Life.



What Y'all Gon' Do With Me?

(Let's talk about it)

The African-American Spiritual and Ethical Guide to End of Life Care

By Gloria Thomas Anderson, MSW

Your Legacy—Your Life

What’s really important at the end of life?

- Building memories
- Leaving a legacy to be remembered by

Embracing Life... Releasing Life

Tomorrow's Hope

Hope is the substance of renewal and strength that
gives courage to go on.
Hope is the quiet stillness comforting the soul
as a broken heart mourns.
Hope is the light that merges with faith,
a new beginning to be born.
Such is the precious gift of tomorrow's hope—
a treasured jewel to adorn.

Community Building/Collaboration

☐ Be a key "End of Life Care Provider" in your community:

  - Churches/Clergy
  - Social Services Organization
  - Health Care Organizations
  - Hospice and Palliative Care Organizations
  - Political Representatives
  - Families and Friends

What Can You Do To Help Educate the African-American Community about End of Life Care?

Please order copies of *The African-American Spiritual and Ethical Guide to End of Life Care*!

Mail Requests to:

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Phone: (913) 433-3877

Email: gloria@hearttones.com Website: www.hearttones.com

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ATTACHMENT 5N

Licensed Hospices in the Service Area, TDOH

Hospice Agencies Licensed to Serve Listed Counties

Health Statistics ID	Agency County	Agency	Type
05602	Blount	Blount Memorial Hospital Hospice	Hospice
06063 & 066	Bradley	Adoration Home Health & Hospice Care East TN	Both
06603	Bradley	Kindred Hospice	Hospice
19694	Davidson	Avalon Hospice	Hospice
33603	Hamilton	Amedisys Hospice an Adventa Company	Hospice
33643	Hamilton	Avalon Hospice	Hospice
33653	Hamilton	Caris Healthcare	Hospice
33673	Hamilton	Hearth Hospice of Tennessee	Hospice
33613	Hamilton	Hospice of Chattanooga Inc	Hospice
47602	Knox	Amedisys Hospice an Adventa Company	Hospice
47682	Knox	Caris Healthcare	Hospice
47402 & 476	Knox	Covenant Homecare	Both
47132 & 476	Knox	UTMCK-Home Care Services: Hospice & Home Care	Both
71604	Putnam	Kindred Hospice	Hospice

Source: Health Facilities Commission/Licensure Division - 2/17/2023

Hospice Agencies Licensed to Serve Listed Counties

Agency County	Agency	Type	Licensed County	County Contains Home Office	County Contains Branch Office
Bradley	Adoration Home Health & Hospice Care East TN	Both	Bledsoe	No	No
Davidson	Avalon Hospice	Hospice	Bledsoe	No	No
Hamilton	Amedisys Hospice an Adventa Company	Hospice	Bledsoe	No	No
Hamilton	Avalon Hospice	Hospice	Bledsoe	No	No
Hamilton	Caris Healthcare	Hospice	Bledsoe	No	No
Hamilton	Hearth Hospice of Tennessee	Hospice	Bledsoe	No	No
Hamilton	Hospice of Chattanooga Inc	Hospice	Bledsoe	No	No
Knox	Amedisys Hospice an Adventa Company	Hospice	Bledsoe	No	No
Putnam	Kindred Hospice	Hospice	Bledsoe	No	No
	Number of Licensed Hospice Agencies in Bledsoe County		9		
Bradley	Adoration Home Health & Hospice Care East TN	Both	Bradley	Yes	No
Bradley	Kindred Hospice	Hospice	Bradley	Yes	No
Davidson	Avalon Hospice	Hospice	Bradley	No	No
Hamilton	Amedisys Hospice an Adventa Company	Hospice	Bradley	No	No
Hamilton	Avalon Hospice	Hospice	Bradley	No	No
Hamilton	Caris Healthcare	Hospice	Bradley	No	No
Hamilton	Hearth Hospice of Tennessee	Hospice	Bradley	No	Yes
Hamilton	Hospice of Chattanooga Inc	Hospice	Bradley	No	Yes
Knox	Amedisys Hospice an Adventa Company	Hospice	Bradley	No	No
	Number of Licensed Hospice Agencies in Bradley County		9		
Bradley	Adoration Home Health & Hospice Care East TN	Both	Hamilton	No	Yes
Bradley	Kindred Hospice	Hospice	Hamilton	No	No
Davidson	Avalon Hospice	Hospice	Hamilton	No	Yes
Hamilton	Amedisys Hospice an Adventa Company	Hospice	Hamilton	Yes	No
Hamilton	Avalon Hospice	Hospice	Hamilton	Yes	No
Hamilton	Caris Healthcare	Hospice	Hamilton	Yes	No
Hamilton	Hearth Hospice of Tennessee	Hospice	Hamilton	No	No
Hamilton	Hospice of Chattanooga Inc	Hospice	Hamilton	Yes	Yes
Knox	Amedisys Hospice an Adventa Company	Hospice	Hamilton	No	No
	Number of Licensed Hospice Agencies in Hamilton County		9		

Hospice Agencies Licensed to Serve Listed Counties

Agency County	Agency	Type	Licensed County	County Contains Home Office	County Contains Branch Office
Bradley	Adoration Home Health & Hospice Care East TN	Both	Marion	No	Yes
Davidson	Avalon Hospice	Hospice	Marion	No	No
Hamilton	Amedisys Hospice an Adventa Company	Hospice	Marion	No	Yes
Hamilton	Avalon Hospice	Hospice	Marion	No	No
Hamilton	Caris Healthcare	Hospice	Marion	No	No
Hamilton	Hearth Hospice of Tennessee	Hospice	Marion	No	No
Hamilton	Hospice of Chattanooga Inc	Hospice	Marion	No	Yes
	Number of Licensed Hospice Agencies in Marion County		**7**		
Bradley	Adoration Home Health & Hospice Care East TN	Both	McMinn	No	No
Bradley	Kindred Hospice	Hospice	McMinn	No	No
Davidson	Avalon Hospice	Hospice	McMinn	No	No
Hamilton	Amedisys Hospice an Adventa Company	Hospice	McMinn	No	Yes
Hamilton	Avalon Hospice	Hospice	McMinn	No	No
Hamilton	Caris Healthcare	Hospice	McMinn	No	Yes
Hamilton	Hearth Hospice of Tennessee	Hospice	McMinn	No	No
Hamilton	Hospice of Chattanooga Inc	Hospice	McMinn	No	Yes
Knox	Amedisys Hospice an Adventa Company	Hospice	McMinn	No	No
Knox	Caris Healthcare	Hospice	McMinn	No	No
	Number of Licensed Hospice Agencies in McMinn County		**10**		
Bradley	Adoration Home Health & Hospice Care East TN	Both	Meigs	No	No
Bradley	Kindred Hospice	Hospice	Meigs	No	No
Davidson	Avalon Hospice	Hospice	Meigs	No	No
Hamilton	Amedisys Hospice an Adventa Company	Hospice	Meigs	No	No
Hamilton	Avalon Hospice	Hospice	Meigs	No	No
Hamilton	Caris Healthcare	Hospice	Meigs	No	No
Hamilton	Hearth Hospice of Tennessee	Hospice	Meigs	No	No
Hamilton	Hospice of Chattanooga Inc	Hospice	Meigs	No	No
Knox	Amedisys Hospice an Adventa Company	Hospice	Meigs	No	No
	Number of Licensed Hospice Agencies in Meigs County		**9**		

Hospice Agencies Licensed to Serve Listed Counties

Agency County	Agency	Type	Licensed County	County Contains Home Office	County Contains Branch Office
Blount	Blount Memorial Hospital Hospice	Hospice	Monroe	No	No
Bradley	Adoration Home Health & Hospice Care East TN	Both	Monroe	No	Yes
Davidson	Avalon Hospice	Hospice	Monroe	No	No
Knox	Amedisys Hospice an Adventa Company	Hospice	Monroe	No	Yes
Knox	Caris Healthcare	Hospice	Monroe	No	No
Knox	Covenant Homecare	Both	Monroe	No	No
Knox	UTMCK-Home Care Services: Hospice & Home Care	Both	Monroe	No	No
	Number of Licensed Hospice Agencies in Monroe County		**7**		
Bradley	Adoration Home Health & Hospice Care East TN	Both	Polk	No	No
Bradley	Kindred Hospice	Hospice	Polk	No	No
Davidson	Avalon Hospice	Hospice	Polk	No	No
Hamilton	Amedisys Hospice an Adventa Company	Hospice	Polk	No	No
Hamilton	Avalon Hospice	Hospice	Polk	No	No
Hamilton	Hearth Hospice of Tennessee	Hospice	Polk	No	No
Hamilton	Hospice of Chattanooga Inc	Hospice	Polk	No	No
Knox	Amedisys Hospice an Adventa Company	Hospice	Polk	No	No
	Number of Licensed Hospice Agencies in Polk County		**8**		
Bradley	Adoration Home Health & Hospice Care East TN	Both	Rhea	No	No
Davidson	Avalon Hospice	Hospice	Rhea	No	No
Hamilton	Amedisys Hospice an Adventa Company	Hospice	Rhea	No	No
Hamilton	Avalon Hospice	Hospice	Rhea	No	No
Hamilton	Caris Healthcare	Hospice	Rhea	No	No
Hamilton	Hearth Hospice of Tennessee	Hospice	Rhea	No	No
Hamilton	Hospice of Chattanooga Inc	Hospice	Rhea	No	Yes
Knox	Amedisys Hospice an Adventa Company	Hospice	Rhea	No	No
	Number of Licensed Hospice Agencies in Rhea County		**8**		
Bradley	Adoration Home Health & Hospice Care East TN	Both	Sequatchie	No	No
Davidson	Avalon Hospice	Hospice	Sequatchie	No	No
Hamilton	Amedisys Hospice an Adventa Company	Hospice	Sequatchie	No	No
Hamilton	Avalon Hospice	Hospice	Sequatchie	No	No

Hospice Agencies Licensed to Serve Listed Counties

Agency County	Agency	Type	Licensed County	County Contains Home Office	County Contains Branch Office
Hamilton	Caris Healthcare	Hospice	Sequatchie	No	No
Hamilton	Hearth Hospice of Tennessee	Hospice	Sequatchie	No	No
Hamilton	Hospice of Chattanooga Inc	Hospice	Sequatchie	No	No
Knox	Amedisys Hospice an Adventa Company	Hospice	Sequatchie	No	No
	Number of Licensed Hospice Agencies in Sequatchie County		**8**		

Source: Health Facilities Commission/Licensure Division - 2/17/2023

ATTACHMENT 1C

Sample Hospice Service Contracts

Skilled Nursing Facility, General Inpatient and Respite Care

SAMPLE HOSPICE-SKILLED NURSING FACILITY CONTRACT

THIS AGREEMENT is executed as of this _________ and effective as of the _________ by and between _________________________________ with its principal place of business located at ____________________________("Nursing Home"), and Heritage Hospice, LLC("Hospice"), with its principal place of business at

RECITALS

WHEREAS, Hospice operates a Medicare certified and state licensed hospice program which provides interdisciplinary services for the palliation and management of patients with terminal illness. Hospice desires to provide hospice services to eligible Nursing Home residents in coordination with the management and staff of Nursing Home; and

WHEREAS, Nursing Home operates a Medicare certified and state licensed nursing facility, and is skilled and experienced in the provision of long term care services to its residents;

WHEREAS, Nursing Home has among its residents terminally ill individuals who are eligible to elect hospice services, and Nursing Home desires to make hospice services available to such terminally ill individuals consistent with this Agreement.

NOW, THEREFORE, in consideration of the premises and mutual covenants contained herein, the Parties agree as follows:

I.
DEFINITIONS

1. "**Affiliate**" shall mean any person, corporation, firm, partnership or other entity which directly controls, is controlled by or is under common control with a Party to this Agreement.

2. "**Attending Physician**" means a doctor of medicine or osteopathy, duly licensed under applicable State and local laws and regulations, who serves the primary role in delivery of medical care to a Hospice Patient and who is an active member, in good standing, of the medical staff of a hospital which is duly licensed under applicable federal, State and local laws and regulations.

3. "**Effective Date**" shall mean ____________.

4. "**Eligible Residents**" shall mean individuals residing in Nursing Home who request hospice services and who: (i) are eligible for hospice services under Medicare Part A or the State Medicaid Program, who have other third party payor coverage, or who otherwise elect to pay privately or through commercial insurance for hospice care; (ii) if Medicare eligible, make a hospice benefit election as required by applicable Medicare law and regulations or comparable Medicaid election; if private pay, request services of Hospice; and (iii) meet any other criteria for admission to the Hospice program.

5. "**Facility**" shall mean the nursing facility owned and operated by Nursing Home, which is located at See Exhibit F.

6. "**Hospice Admission Date**" shall mean the date that Hospice accepts an Eligible Resident as a Hospice Patient, and the patient becomes a Hospice Patient that participates in the Hospice program.

7. "**Hospice Admission Criteria**" shall mean the criteria set forth in Exhibit A attached here to, which are used by Hospice to determine whether to admit an Eligible Resident as a Hospice Patient.

8. "**Hospice Care**" shall mean the comprehensive set of services described in Section 1861(dd)(1) of the Social Security Act, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or such patient's family members, as delineated in a specific patient Hospice Plan of Care.

9. "**Hospice Conditions of Participation**" shall mean the Medicare Conditions of Participation for hospice providers set forth in Part 418 of Title 42 of the Code of Federal Regulations.

10. "**Hospice Interdisciplinary Group**" means a group of persons consisting of Hospice Patient's Attending Physician and a group of Hospice personnel who participate in the establishment of a Hospice Plan of Care, periodically review and update such plan, provide or supervise the care and services offered by Hospice and Nursing Home, and establish policies and protocols governing the day-to-day provision of such care, including at least the following individuals: a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor.

11. "**Hospice Medical Director**" shall mean a duly licensed doctor of medicine or osteopathy employed by or contracted with Hospice who assumes overall responsibility for the medical component of the Hospice Patient's care program and who is responsible for determining if the Hospice Patient is Terminally Ill and documenting this status as required by the Hospice Conditions of Participation.

12. "**Hospice Patient**" shall mean a terminally ill individual who elects to receive Hospice Services, who is accepted by Hospice in accordance with the Hospice Admission Criteria, and who shall have an individualized Hospice Plan of Care developed by the Hospice Interdisciplinary Group.

13. "**Hospice Patient Rights**" shall mean the right to (a) receive effective pain management and symptom control from Hospice for conditions related to the patient's terminal illness; (b) be involved in developing the patient's Hospice Plan of Care; (c) refuse care or treatment; (d) choose the patient's Attending Physician; (e) have a confidential clinical record; (f) be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source and misappropriation of patient property; (g) receive information about the services covered under the hospice benefit; (h) receive information about the scope of services that Hospice will

provide and specific limitations on those services; (i) to have his/her person and property treated with respect.

14. "**Hospice Physician**" means a duly licensed doctor of medicine or osteopathy retained by Hospice to render medical care to Hospice Patients for the palliation and management of the patients' terminal illness and conditions related to such illness in accordance with the applicable Plan of Care.

15. "**Hospice Plan of Care**" means a written care plan for each Hospice Patient, which is developed, implemented, reviewed at specified intervals and revised as necessary by the Interdisciplinary Group in accordance with 42 CFR § 418.56(c).

16. "**Hospice Services**" shall mean the Hospice Home Care Services, Continuous Care, General Inpatient Care, and/or Respite Care to the extent provided by Hospice at Nursing Home or through other contractual arrangement. Hospice Services shall include "Core Hospice Services" and "Non-Core Hospice Services."

    1. "**Core Hospice Services**" shall mean physician services, nursing services, medical social services and counseling services, including but not limited to bereavement counseling, dietary counseling and spiritual counseling services.

    2. "**Non-Core Hospice Services**" shall mean physical therapy, occupational therapy and speech-language pathology services, hospice aide services, homemaker services, and volunteer services.

    3. "**Hospice Home Care Services**" shall mean Hospice Care provided during a day during which a Hospice Patient is at home (residing in the Facility) and is not receiving Continuous Care, Respite Care or General Inpatient Care.

    4. "**Continuous Care**" shall mean the provision of nursing, homemaker or aide services in the Nursing Home for at least eight (8) hours in a twenty-four (24) hour period, for up to twenty-four (24) hours per day to provide predominantly nursing care for the Hospice Patient.

    5. "**General Inpatient Care**" shall mean care that a Hospice Patient receives in an inpatient facility such as a hospital or skilled nursing facility for pain control or acute symptom management related to the terminal illness which cannot be managed in other settings. General Inpatient Care shall include but not be limited to (1) treatment, medication, emergency services, dietary, housekeeping and oxygen services, (2) the services of registered nurses, reasonably acceptable to Hospice, to provide or to direct the provision of care to Hospice Patients as appropriate, and (3) other nursing services including without limitation nursing services needed to keep Hospice Patients comfortable, clean, well-groomed, and protected from accident, injury and infection.

6. "**Respite Care**" shall mean direct daily nursing care furnished to a Hospice Patient in an inpatient facility to provide relief to family members or other person caring for the Hospice Patient at home for a short period (five (5) or less consecutive days) or on an intermittent, non-routine and occasional basis.

17. "**Nursing Home Plan of Care**" shall mean a written care plan established, maintained, reviewed and modified, if necessary, by Nursing Home's interdisciplinary team which includes the Attending Physician, a registered professional nurse with responsibility for the Hospice Patient, and other appropriate staff of the Nursing Facility, and with the participation of Hospice, the Hospice Patient and the Hospice Patient's family to the extent practicable. The Nursing Home Plan of Care shall be consistent with the Hospice Plan of Care for the Hospice Patient.

18. "**Nursing Home Room and Board Services**" shall mean those personal care services provided by Nursing Home as specified in the Hospice Plan of Care or Nursing Home Plan of Care for a Hospice Patient including, but not limited to, providing food, assisting in activities of daily living, and socializing activities; administration of medications; providing and maintaining the cleanliness of the Hospice Patient's room; supervising and assisting in the use of any durable medical equipment and therapies included in the Hospice Plan of Care; providing laundry; and providing usual and customary room furnishings.

19. "**Other Nursing Home Services**" shall mean all items and services specified in Nursing Home Plan of Care and provided by Nursing Home under the Nursing Home Plan of Care which are not related to treatment of the Hospice Patient's terminal illness, including, but not limited to, telephone, guest trays, personal items and television hook-up.

20. "**Palliative Care**" shall mean patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

21. "**Personnel**" shall mean individuals employed or contracted by Nursing Home or Hospice who are duly qualified to provide Hospice Services, Nursing Home Room and Board Services, and/or Other Nursing Home Services under the terms of this Agreement.

22. "**Purchased Hospice Services**" shall mean those Non-Core Hospice Services, General Inpatient or Respite Care that Hospice has contracted with Nursing Home to provide. Such services may include the drugs and pharmaceuticals, durable medical equipment, supplies, therapies, and ancillary services which are related to the Hospice Patient's terminal illness.

23. **Quality Assurance and Performance Improvement Programs**" or "**QA and PI Programs**" shall mean Hospice programs designed to monitor the effectiveness and safety of Hospice Services and quality of care; identify opportunities and priorities for

improvement; track adverse patient events and analyze their causes; and implement preventive actions and mechanisms.

24. "**Terminally Ill**" shall mean that the patient has a medical prognosis that his or her life expectancy is six (6) months or less if the illness runs its normal course.

II.

RESPONSIBILITIES OF HOSPICE

1. Admission to Hospice Program. Subject to the availability Hospice's staff and resources, Hospice shall admit as a Hospice Patient, each Eligible Resident who executes a "Request for the Provision of Hospice Home Care Services to a Nursing Home Resident" in the form attached hereto as Exhibit B as may be amended from time to time (or an equivalent form developed by Hospice), in accordance with the Hospice Admission Criteria.

2. Professional Responsibility. For each Hospice Patient in Nursing Home, Hospice shall assume, retain and maintain responsibility for administrative, financial management and oversight of staff and services for all services provided to Hospice Patient by Nursing Home to ensure the provision of quality of care for Hospice Services provided to such Hospice Patient in accordance with the Hospice Conditions of Participation. All services provided by Nursing Home hereunder shall be (i) authorized by Hospice, (ii) furnished in a safe and effective manner by qualified personnel and (iii) delivered in accordance with the Hospice Patient's Hospice Plan of Care. Hospice shall be responsible for determining the appropriate course of hospice care, including the determination to change the level of services provided, including making arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility as provided by 42 C.F.R. §§ 418.100 and 418.108.

3. Patient Assessments. Hospice shall conduct and document in writing a patient-specific assessment that identifies the Hospice Patient's need for hospice care and services, which shall include all areas of Hospice Care related to the palliation and management of the terminal illness and related conditions in compliance with the Hospice Conditions of Participation and other applicable law.

    1. Initial Assessment. Hospice shall complete an initial assessment of the Hospice Patient within 48 hours after the Hospice Admission (or such earlier time as requested by the Attending Physician, the Hospice Patient or such patient's representative). The initial assessment shall include an evaluation of the Hospice Patient's physical, psychosocial and emotional status related to the terminal illness and related conditions to determine the patient's immediate care and support needs. During this initial assessment, Hospice shall provide the Hospice Patient or his/her representative with verbal and written notice of the Hospice Patient Rights using language and manner understandable to the patient/representative, and shall have the patient/representative sign a document confirming receipt of this information.

2. Comprehensive Assessment. The Hospice Interdisciplinary Group shall complete a comprehensive assessment of the Hospice Patient (in consultation with the patient's Attending Physician) no later than five (5) calendar days after the Hospice Admission. This comprehensive assessment shall identify the physical, psychosocial, emotional, and spiritual needs of the Hospice Patient related to the terminal illness that must be addressed in order to promote the Hospice Patient's well-being, comfort, and dignity throughout the dying process, and shall consider the following: (1) the nature and condition causing admission; (2) complications and risk factors that affect care planning, (3) functional status, including the patient's ability to understand and participate in his or her own care, (4) imminence of death, (5) severity of symptoms, (6) a review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy, including but not limited to effectiveness, side effects, interactions, duplications, and required laboratory monitoring, (7) a bereavement assessment of the patient's family and other individuals, and (8) the need for additional consultations, evaluations or referrals. The comprehensive assessment must also include data elements that allow for measurement of outcomes, as further described in 42 C.F.R. §418.54(e).

3. Update of Comprehensive Assessment. As frequently as required by the Hospice Patient's condition, but no less frequently than every fifteen (15) days, the Hospice Interdisciplinary Group (in collaboration with the patient's Attending Physician) shall evaluate the Hospice Patient's progress toward desired outcomes and response to care, and shall update the written comprehensive assessment.

4. Certification of Terminal Illness. Hospice Medical Director or his/her physician designee shall review the clinical information for each Hospice Patient and shall provide written certification that it is anticipated that the patient's life expectancy is expected to be six (6) months or less if the illness runs its normal course.

4. Hospice Plan of Care. The Hospice Interdisciplinary Group (in collaboration with the Attending Physician, the Hospice Patient and his/her family or primary caregiver, and the Nursing Home representatives to the extent possible) shall prepare an individualized written Hospice Plan of Care for each Hospice Patient in the Nursing Home. The Hospice Plan of Care shall specify the Hospice Care and Hospice Services necessary to meet the needs of the Hospice Patient and his/her family as identified in the initial, comprehensive and updated assessments as such needs relate to the terminal illness and related conditions, and shall include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: (a) interventions to manage pain and symptoms, (b) the scope and frequency of services necessary to meet the specific patient and family needs, (c) measurable outcomes anticipated from implementing and coordinating the Hospice Plan of Care, (d) drugs, treatment, medical supplies and appliances necessary to meet the needs of the Hospice

Patient, and (e) clinical record documentation of the patient's or representative's level of understanding, involvement, and agreement with the Hospice Plan of Care.

1. All Hospice Care shall be provided in accordance with the Hospice Plan of Care. The Hospice Plan of Care shall reflect the participation of Hospice, Nursing Home, and Hospice Patient and his/her family to the extent possible. In addition, the Hospice Plan of Care shall specifically identify which provider is responsible for performing the care and services included in Hospice Plan of Care.

2. Hospice shall notify Nursing Home, the Nursing Home's nursing staff, the Attending Physician, and the Hospice Patient (or his/her representative) of any modifications to the Hospice Plan of Care, and shall discuss such modifications with such individual/entities as appropriate.

3. Hospice shall provide the Hospice Patient and his/her primary care giver(s) (including Nursing Home, as applicable) with education and training to allow the appropriate performance of responsibilities identified in the Hospice Plan of Care.

4. As frequently as required by the Hospice Patient's condition, but no less frequently than every fifteen (15) days, the Hospice Interdisciplinary Committee (in collaboration with the patient's Attending Physician) shall review, revise and document the Hospice Plan of Care to include information from updated patient assessments, and progress toward outcomes and goals specified in the Hospice Plan of Care. All such updates shall be communicated to Nursing Home.

5. Hospice Services. Hospice shall provide Hospice Services to Hospice Patients in the Nursing Home at the same level and to the same extent as Hospice would provide those services if the patient were living in a private home. Hospice Services shall include without limitation providing medical direction and management of the patient; nursing services; counseling (including spiritual, dietary and bereavement counseling); social work services; provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. Hospice Services shall not include Nursing Home Room and Board Services and Other Nursing Home Services. Hospice shall provide substantially all Core Hospice Services through Hospice's employees.

    1. Coordination of Services. For each Hospice Patient in the Nursing Home, the Hospice Interdisciplinary Group shall (1) maintain responsibility for directing, coordinating, and supervising the Hospice Care and Hospice Services provided under this Agreement, (2) require all care and services provided to Hospice Patients shall be provided in accordance with the

Hospice Plan of Care, based on all Hospice assessments of the patient and family needs.

   1. Hospice shall designate a member of the Hospice Interdisciplinary Group who shall (a) coordinate the overall Hospice Care of the Hospice Patient, including but not limited to coordinating care between Hospice and Nursing Home, (b) communicate with Nursing Home representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family and (c) ensure that the Hospice Interdisciplinary Group communicates with the medical director of the Nursing Home, the Attending Physician, Hospice Physicians and other healthcare providers that provide non-hospice services to the Hospice Patient, as needed to coordinate the Hospice Care for such patient, and to coordinate Hospice Services with non-hospice medical services provided to such patient.

   2. Hospice shall provide Nursing Home with the following information: (a) the most recent individualized Hospice Plan of Care for each Hospice Patient; (b) the Patient's election form for Hospice Services and any advance directives specific to each patient; (c) each Hospice Patient's physician certification and recertification of terminal illness; (d) names and contact information for hospice personnel involved in hospice care of each patient; (e) instructions on how to access Hospice's 24-hour on-call system; (f) specific medication information for each Hospice Patient; and (g) physician orders for Hospice Physician Services for each Hospice Patient.

2. Hospice Physician Services. Hospice Medical Director and Hospice Physicians (in conjunction with the Attending Physician) shall be responsible for providing Hospice Patients with medical services for the palliation and management of the terminal illness and conditions related to the terminal illness. Physician services shall be routinely available 24-hours per day, 7 days per week. Hospice Physicians and/or the Medical Director shall evaluate each Hospice Patient in the Nursing Home as necessary and in accordance with applicable federal and State laws, and the Hospice Plan of Care for such patient. The services of Hospice Physicians shall relate solely to the Hospice Patient's terminal illness and, therefore, shall not duplicate or replace the services of the Attending Physician. In performing medical services, Hospice Physicians shall function under the supervision of the Hospice Medical Director.

3. Hospice Nursing Services. Hospice shall provide nursing care and services by or under the supervision of a registered nurse to meet the nursing needs of the Hospice Patient as needed and required by the Hospice Patient's

initial, comprehensive, and updated assessments. Nursing services shall be routinely available 24 hours per day, 7 days per week. Notwithstanding the foregoing, Hospice may use Nursing Home nursing personnel (and Nursing Home shall provide such nursing personnel at Hospice's request), to assist in the administration of prescribed therapies included in the Hospice Plan of Care only to the extent that Hospice would routinely use the services of a Hospice Patient's family member to implement the plan of care if the patient was residing in a private home.

4. Medical Social Services. Hospice shall provide medical social services by a qualified social worker under the direction of a Hospice Physician, as needed to meet the Hospice Patient's and his/her family's needs and based on the Hospice Patient's psychosocial assessment.

5. Counseling Services. Hospice shall provide counseling services to Hospice Patients and their families to help minimize the stress and problems that arise from the patient's terminal illness, related conditions, and the dying process. Counseling services shall include, but are not limited to, bereavement counseling, dietary counseling and spiritual counseling, as further described in 42 C.F.R. §418.64(d).

    1. Bereavement Counseling. Hospice shall (a) provide bereavement counseling services under the supervision of a qualified professional with experience or education in grief or loss counseling, (b) make bereavement counseling services available to family and others listed in the bereavement plan of care (including residents of the Nursing Home) for up to one (1) year following the death of a Hospice Patient, (c) ensure that bereavement services reflect the needs of the bereaved, and (d) develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery.

    2. Dietary Counseling. When identified in the plan of care, Hospice shall provide dietary counseling by dietitians, nurses and other individuals qualified to assure that the dietary needs of the Hospice Patient are met.

    3. Spiritual Counseling. Hospice shall (a) provide an assessment of the Hospice Patient's and his/her family's spiritual needs, (b) provide spiritual counseling to meet these needs in accordance with the Hospice Patient's and his/her family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires, (c) make all reasonable efforts (to the best of Hospice's ability) to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs, and (d) advise Hospice Patients and their families of these spiritual counseling services.

    6. Twenty-Four Hour Availability. Hospice shall provide one or more Hospice employees to be available twenty-four (24) hours per day for services and consultation related to the Hospice Patient's terminal illness. Hospice shall supply Nursing Home with a list of names and phone numbers of individuals available to provide such services and consultation.

6. Non-Core Hospice Services. Hospice shall provide Non-Core Hospice Services directly or under arrangements that comply with the applicable Hospice Conditions of Participation.

7. Drugs and Biologicals. For each Hospice Patient in a Nursing Home, Hospice shall provide (on a 24 hour per day, 7 day per week basis), all drugs, pharmaceuticals and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the patient's Hospice Plan of Care. Hospice shall provide such medications in accordance with the applicable requirements set forth in 42 C.F.R. §418.106.

8. Medical Equipment and Medical Supplies. For each Hospice Patient in the Nursing Home, Hospice shall provide all necessary and appropriate medical equipment and medical supplies related to the palliation and management of the terminal illness and related conditions, as identified in the patient's Hospice Plan of Care; provided that such medical equipment and supplies are not ordinarily provided by Nursing Home to its residents, nor included in the basic room and board charge. Hospice shall be responsible for maintenance, repair and appropriate use of such equipment and supplies in accordance with the applicable requirements set forth in 42 C.F.R. § 418.106.

9. Short-Term Inpatient Care. Hospice shall make inpatient care available for Hospice Patients, as needed for pain control, symptom management and respite purposes, which may be provided by Nursing Home upon request by Hospice. In such event, Nursing Home shall provide 24 hour nursing services that meets the nursing needs of Hospice Patient, furnished in accordance with each patient's Hospice Plan of Care and shall keep Hospice Patient comfortable, clean, well-groomed and protected from accident, injury and infection.

    1. Change in Level of Care. Based on the needs and conditions of the Hospice Patient, Hospice, in consultation with the Attending Physician and Nursing Home, may change the level of care being furnished to a Hospice Patient from Hospice Home Care to Continuous Care or General Inpatient Care. If the Hospice Patient requires a transfer from the Nursing Home to a different level of care, Hospice shall be responsible for arranging the transfer and shall remain responsible for any necessary Continuous Care, General Inpatient Care or Respite Services that are necessary and related to the Hospice Patient's terminal illness or a related condition.

    2. Continuous Care. If a Hospice Patient experiences a crisis, as defined by Medicare regulations as a period in which the individual requires continuous care to achieve palliation or management of acute medical

symptoms, Hospice shall place nursing, homemaker or aide services in the Nursing Home twenty-four (24) hours per day during the crisis to provide predominantly nursing care for the Hospice Patient until the Hospice Patient is clinically able to return to Hospice Home Care or requires transfer to General Inpatient Care.

3. General Inpatient Care. If a Hospice Patient experiences chronic or acute symptoms which, in the judgment of Hospice and the Hospice Patient's Attending Physician, cannot be effectively managed through Hospice Home Care Services or Continuous Care, Hospice agrees to provide short-term General Inpatient Care to the Hospice Patient in an inpatient facility (hospital or free standing hospice), or at Nursing Home if an RN is on duty and available to provide direct care twenty-four (24) hours a day. If the Hospice Patient so requests and Hospice wishes to obtain General Inpatient Care from Nursing Home, Hospice shall discuss the provision of General Inpatient Care with Nursing Home's Administrator and Director of Nursing. If Nursing Home has established policies for General Inpatient Care consistent with Hospice requirements set forth at 42 C.F.R. §418.108 and can provide the needed General Inpatient Care services, Hospice may either admit the Hospice Patient to Nursing Home for General Inpatient Care or, if the Hospice Patient is receiving Respite Care or Continuous Care at Nursing Home, transfer the Hospice Patient to General Inpatient Care status. If a Hospice Patient is reclassified to General Inpatient Care to be provided by Nursing Home, the Hospice Patient shall be transferred to a nursing home bed in Nursing Home which meets the Medicare requirements for General Inpatient Care stated at 42 CFR §110(b) and (e). Nursing Home staff shall follow the Hospice Plan of Care for that Hospice Patient while such patient is receiving General Inpatient Care from Nursing Home. Charges for General Inpatient Care at Nursing Home shall be reimbursed according to Article VI of this Agreement.

10. Transportation/Ambulance. If a Hospice Patient in the Nursing Home requires transportation, by ambulance or otherwise, from Nursing Home to an inpatient facility or elsewhere as a result of the terminal illness or a related condition, Hospice shall provide or arrange for such transportation or ambulance. Any such ambulance transportation must be authorized by Hospice before transporting the Hospice Patient.

11. Training, Education and Assessment. Hospice shall provide orientation and training for all Personnel, including but not limited to the staff's specific job duties, and Hospice's philosophy, policies and procedures regarding methods of comfort, pain control, and symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements. In addition, Hospice shall assess the skills and competence of all Personnel (including without limitation volunteers), and, as necessary, provide in-service training and education programs where required. Hospice shall have written policies and procedures describing its method(s) of assessment of competency and

maintain a written description of the in-service training provided during the previous 12-month period.

12. Investigations. Hospice shall report to Nursing Home's Administrator all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to Hospice within 24 hours of Hospice becoming aware of the alleged violation. In addition to investigating and documenting alleged violations of Hospice Patient Rights by any individual or entity providing services under this Agreement, Nursing Home shall:

    1. report to Hospice administration immediately when Nursing Home becomes aware of all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services under this Agreement;

    2. investigate immediately all alleged violations involving anyone furnishing services under this Agreement and Hospice shall take immediate action to prevent further potential violations while the alleged violation is being verified;

    3. take appropriate corrective action in accordance with State law if the alleged violation is verified by Hospice, Nursing Home, or any outside body having jurisdiction over such occurrence, such as the State licensing agency and local law enforcement; and

    4. require that all violations are reported to State and local bodies having jurisdiction over such occurrence (including to the State licensing agency and local law enforcement) in accordance with applicable legal requirements.

13. Participation in Quality Assessment and Performance Improvement Activities. Nursing Home and its Personnel shall participate in Hospice's QA and PI Programs as directed by Hospice. Nursing Home shall also participate in performance improvement projects as designed and implemented by Hospice.

14. Continuation of Care. Nursing Home shall not discontinue or reduce care provided to a Medicare or Medicaid beneficiary because of the beneficiary's inability to pay for that care.

III.
RESPONSIBILITIES OF NURSING HOME

1. Admission and Transfer. Nursing Home shall admit Eligible Residents to Nursing Home based on Nursing Home's Admission Policy (attached hereto as Exhibit C), bed availability and in accordance with Nursing Home's Resident Handbook. Nursing Home also shall admit a Hospice Patient to Nursing Home for Respite Care or General Inpatient Care in accordance with Exhibit C. Nursing Home shall not transfer any Hospice Patient to another care setting without the prior approval of Hospice.

2. Education of Nursing Home Residents. Nursing Home shall assess residents who may be appropriate for Hospice Services and make each Terminally Ill resident of Nursing Home aware of the potential availability of Hospice Services through Hospice or any other hospice of the resident's selection.

3. Nursing Home Plan of Care. In accordance with applicable federal and State laws and regulations, Nursing Home shall prepare and/or revise the Nursing Home Plan of Care to be consistent with the most recent Hospice Plan of Care for each new Hospice Patient in Nursing Home and agrees to coordinate with Hospice the care and services provided to Hospice Patients. Nursing Home shall furnish Hospice with a copy of the Nursing Home Plan of Care for each Hospice Patient. Nursing Home will consult with Hospice, as reasonably necessary, with respect to any modification of Nursing Home Plan of Care for a Hospice Patient.

4. Provision of Nursing Home Services. Nursing Home shall furnish to Hospice Patient in Nursing Home all non-hospice services normally provided to other residents, and shall furnish such services by qualified Personnel in a safe and effective manner. Nursing Home agrees that it will not provide Hospice Services to Hospice Patients unless retained by Hospice to do so under Sections 6.3 or 6.4. With respect to management of a Hospice Patient's terminal illness, Nursing Home shall make records of care and services to the patient available to Hospice, subject to applicable law. Nursing Home shall provide Nursing Home Room and Board Services and Other Nursing Home Services unrelated to the patient's terminal illness as required under the Conditions of Participation to the extent such services are consistent with the Hospice Plan of Care, including without limitation, personal care services, including assistance in activities, administration of medications, maintaining cleanliness of a resident's room and supervising the use of Nursing Home durable medical equipment and prescribed therapies. Nursing Home shall be responsible for furnishing 24-hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver if Hospice Patient resided at a private home, and meeting the personal care and nursing needs at the same level of care provided before the patient elected to become a Hospice Patient.

    1. Coordination of Services.

        1. Nursing Home shall designate a staff member who shall (a) coordinate care with the Hospice, (b) have a clinical background, (c) be able to assess the resident or have access to someone who does, (d) collaborate with Hospice representatives and other external providers, and (e) insure that the Nursing Home staff communicates with the Hospice Medical Director, the patient's attending physician, and other practitioners involved in care.

    2. Nursing Home Orientation.

        1. Nursing Home staff must provide orientation to Hospice staff furnishing care to Nursing Home residents. Orientation to include policies and

procedures of the Nursing Home including patient rights, appropriate forms, and record keeping.

5. Space, Access and Visitation. Nursing Home shall provide Hospice Patients with physical space designed and equipped for the comfort and privacy of the patient and family members with a reasonably home-like atmosphere, which is designed to preserve the dignity, comfort, and privacy of patients. Nursing Home shall permit reasonable access and visiting privileges (including visits by children of any age) on a twenty-four (24) hour a day basis. When providing Respite Care, Nursing Home shall accommodate Hospice Patient and family request for a single room wherever possible. Each room must (i) be at or above grade level; (ii) contain a suitable bed and other appropriate furniture for each patient; (iii) have closet space that provides security and privacy for clothing and personal belongings; (iv) accommodate no more than two patients and their family members; (v) provide at least 80 square feet for each residing patient in a double room and at least 100 square feet for each patient residing in a single room; and (vi) be equipped with an easily-activated, functioning device accessible to the patient, that is used for calling for assistance. Nursing Home shall provide adequate space, located conveniently to Hospice Patients, for private visiting among Hospice Patients and families and other visitors, and adequate accommodations for family members to remain with the Hospice Patient throughout day, evening, and night hours and for family privacy after the death of a Hospice Patient. Nursing Home shall permit Hospice employees, contractors, agents and volunteers free and complete access to Nursing Home twenty-four (24) hours per day, as necessary, to permit Hospice to counsel, treat, attend and provide Hospice Services to each Hospice Patient.

6. Provision of Respite Care and General Inpatient Care. If Nursing Home provides Respite Care or General Inpatient Care, Nursing Home shall provide Respite Care and/or General Inpatient Care (as applicable) on a 24-hour basis in accordance with the conditions of Participation set forth at 42 C.F.R § 418.108. Without limiting the foregoing, Nursing Home shall furnish General Inpatient Care in accordance with the Hospice Plan of Care, which shall specify the inpatient services to be furnished, and coordinate the Nursing Home Plan of Care with the most recent Hospice Plan of Care. Nursing Home's medical records shall include a record of all General Inpatient Care services provided by Nursing Home to Hospice Patients. Upon the Hospice Patient's discharge from General Inpatient Care, Nursing Home shall furnish a discharge summary to Hospice and, if requested by Hospice, a complete copy of the medical record. When providing Respite Care or General Inpatient Care, Nursing Home shall have twenty-four (24) hour appropriate nursing services on each shift to provide direct patient care to the Hospice Patient. Nursing Home's nursing services shall be sufficient to meet total nursing needs and shall be in accordance with Hospice's and Nursing Home's Plans of Care.

7. Communication. Subject to applicable laws and regulations regarding confidentiality of patient information, Nursing Home shall communicate to Hospice, in a timely manner, all pertinent information concerning each Hospice Patient. Without limiting the generality of the foregoing, Nursing Home shall immediately notify Hospice if a Hospice Patient in Nursing Home (1) develops a significant change in physical, mental,

social, or emotional status; (2) develops clinical complications that may require a need to alter the Hospice Plan of Care; (3) requires transfer from the Facility for any condition; or (4) dies.

8. Credentialing of Hospice Physicians. Nursing Home shall grant full staff privileges to the Hospice Medical Director and to Hospice Physicians upon application and qualification so long as such privileges are in accordance with Nursing Home's policies and procedures.

IV.

SERVICES TO BE PERFORMED COOPERATIVELY BY HOSPICE AND NURSING HOME

1. Joint Responsibility. Hospice shall provide services as required by Article II of the Agreement and Nursing Home shall provide services as required by Article III of this Agreement. In addition, Hospice and Nursing Home shall:

    1. Furnish each other with current information documenting the appropriate licensure and credentials of all personnel and training of volunteers providing care to or visiting Hospice Patients.

    2. Furnish each other with documentation of each entity's State and federal licensure and/or certification.

    3. Subject to applicable law, provide each other with access to all records of Hospice Services rendered to the Hospice Patient.

    4. Attend and participate in each other's interdisciplinary group conferences held to develop and evaluate the Hospice Plan of Care and Nursing Home Plan of Care.

    5. Cooperate in reviewing the quality and appropriateness of Hospice Services.

    6. Perform and furnish services for Hospice Patients in accordance with this Agreement.

    7. Inform each Hospice Patient of, and protect and promote the Hospice Patient's exercise of, the Hospice Patient Rights as set forth in 42 C.F.R. §418.52, ensure that each Hospice Patient receives all services under this Agreement in a manner that is consistent with and preserves such rights, and establish a system that allows the Hospice Patient to exercise Hospice Patient Rights without fear of discrimination or reprisal.

    8. Mutually establish policies and protocols for the care of the Hospice Patient.

    9. Work together to provide bereavement services to Nursing Home Personnel.

2. Compliance with Laws, Regulations and Policies. The parties agree that the services provided hereunder shall be provided in accordance with all applicable State, Federal and local laws and regulations, and with the requirements of all regulatory agencies and third party payors applicable to Hospice and Nursing Home.

3. No Exclusion. Each party represents and warrants that neither the party nor any person or entity providing services for such party under this Agreement are, or have been in the past, excluded from participation in Medicare, Medicaid or any other government third party payment program. In addition, each party agrees that it shall, and shall require its employees and/or agents to, immediately notify the other party if any such termination or exclusion occurs during the term of this Agreement.

4. Place of Residence. This Agreement is entered into with the understanding that Nursing Home constitutes the Eligible Resident's place of residence for the purpose of complying with Medicare or Medicaid Hospice admission criteria or other third party payor admission criteria.

5. Liaison. On or prior to the execution of this Agreement, Hospice and Nursing Home shall each designate one (1) representative ("Representative") to facilitate cooperative efforts in performance of their respective obligations under this Agreement. The Representatives shall meet as necessary to establish a mutually satisfactory working relationship as required to provide care to Hospice Patients under this Agreement. Hospice and Nursing Home shall promptly notify the other party of any change in its Representatives.

6. Personnel Qualifications and Criminal Background Checks. All Personnel, whether for Hospice or Nursing Home, or by employment or under arrangement, shall meet the applicable requirements set forth in 42 C.F.R. §418.114 and State law. Without limiting the foregoing, Nursing Home shall obtain a criminal background check on all employees who have direct contact with Hospice Patients or access to such patient's records. The parties understand and agree that all criminal background checks performed as required by this Agreement shall be obtained in accordance with the requirements imposed by State requirements. In the absence of State requirements, criminal background checks must be obtained within three (3) months of the date of employment for all states where the individual has lived or worked in the past three (3) years.

V.
RECORDS

1. Maintenance and Retention of Records. Nursing Home and Hospice shall each prepare and maintain complete and appropriate clinical records concerning each Hospice Patient in Nursing Home in accordance with prudent record keeping procedures, their own policies and procedures, applicable federal and State law and regulations, and applicable Medicare and Medicaid program guidelines. Nursing Home and Hospice shall each retain such records for six (6) years from the date of death or discharge of each Hospice Patient or such other time period as required by applicable State law.

2. Content. The clinical record shall contain past and current findings for each Hospice Patient, and shall make correct clinical information available to the Attending Physician and Hospice staff. All entries in the clinical record shall be legible, clear, complete, and appropriately authenticated and dated in accordance with Hospice policy and currently accepted standards of practice.

3. Access. Subject to applicable law, Nursing Home and Hospice shall each permit the other to review and make photocopies of medical records relating to the provision of services under this Agreement. Each party shall bear any cost of photocopying the other party's records.

4. Protection of Information. Hospice and Nursing Home shall maintain the clinical record in compliance with the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The clinical record, its contents and the information contained therein shall be safeguarded against loss or unauthorized use.

VI.

FINANCIAL RESPONSIBILITY

1. Responsibility of Hospice. For each Hospice Patient who has signed Hospice election form, Hospice shall bear full financial responsibility for all Hospice Services related to the Hospice Patient's terminal illness. Hospice shall pay for pharmaceuticals, medical supplies, equipment and ancillary services, including physical, occupational and speech therapies, for a Hospice Patient as long as such pharmaceuticals, supplies, equipment and ancillary services are related to the terminal illness and palliative in nature, are furnished pursuant to this Agreement, and are not normally provided as Nursing Home Room and Board Services. With express authorization of Hospice, certain Non-Core Hospice Services may be purchased directly from Nursing Home or from Nursing Home's suppliers or contractors at Nursing Home's then-current rate for such supplies, equipment and services in accordance with Section 6.3.

2. Responsibility of Nursing Home. Nursing Home shall retain financial responsibility for services unrelated to the terminal illness which are provided to a Hospice Patient in Nursing Home including Nursing Home Room and Board Services, Other Nursing Home Services and non-covered items and services upon the advanced written request of the Hospice Patient, including ancillaries not related to the Hospice Patient's terminal illness and not designated in the Hospice Plan of Care. Nursing Home shall bear no responsibility for the provision of, or payment for, any services or items required by the Hospice Plan of Care for management of the terminal illness unless purchased by Hospice from Nursing Home under Sections 6.3 or 6.4.

3. Purchase of Services by Hospice from Nursing Home. Hospice may purchase from Nursing Home certain Non-Core Hospice Services and other services and supplies related to the treatment of the Hospice Patient's terminal illness in accordance with the Hospice Plan of Care (such as pharmaceuticals, medical supplies and equipment, oxygen, physical occupational and speech therapy). At the time that Hospice requests

Non-Core Hospice Services for a Hospice Patient, the parties will complete the form attached hereto as Exhibit D. Nursing Home shall invoice Hospice for any services purchased by Hospice for a Hospice Patient and Hospice shall pay such invoices within thirty (30) days of receipt. Nursing Home shall accept such payment as payment in full for Non-Core Hospice Services provided under this Agreement for Medicare Eligible Hospice Patient. Hospice shall be responsible for the collection of any co-payments.

4. Billing and Compensation for General Inpatient Care and Respite Care. For Hospice Patients covered by Medicare, Medicaid, and/or commercial third party insurance, the Parties shall bill and be compensated for General Inpatient Care and Respite Care in accordance with the provisions set forth at Exhibit E.

5. Other. The sharing of fees between a referring agency or individual such as Nursing Home and Hospice is prohibited. Nursing Home shall not seek or accept reimbursement from Hospice or a third party payor in addition to that due to Nursing Home for services or Purchased Hospice Services actually delivered.

VII.
TERM AND TERMINATION

1. Term. The initial term of this Agreement shall be for one (1) year (the "Initial Term") commencing on the Effective Date, unless otherwise terminated in accordance with this Agreement. This Agreement shall thereafter automatically renew for successive one (1) year renewal terms (each, a "Renewal Term"). The Initial Term and any Renewal Terms shall be collectively defined herein as the "Term."

2. Termination. This Agreement may be terminated as follows:

    1. Without Cause Termination. Either Party may terminate this Agreement without cause by furnishing the other Party written notice of such termination thirty (30) days prior to the effective date of such termination, or upon mutual agreement of the Parties.

    2. Immediate Termination. This Agreement will immediately terminate: (1) upon the loss or suspension of either Party's license or status as a participant in the Medicare or Medicaid programs or any other governmental payment programs; (2) upon cancellation of a Party's insurance coverage required under this Agreement; (3) upon the dissolution of such Party's status as a corporate entity under applicable state law; (4) upon the appointment of a receiver for either Party's assets, an assignment by a Party for the benefit of its creditors, or any relief taken or suffered by a Party under any bankruptcy or insolvency act; or (5) as otherwise provided in this Agreement.

    3. Termination for Cause. Either Party may terminate this Agreement if the other Party breaches any of its material obligations hereunder and fails to cure such material breach within fifteen (15) days following written notice specifying the breach from the non-breaching Party.

4. Effect of Termination. In the event that this Agreement is terminated for any reason, as set forth herein, all obligations of either Party shall cease on the effective date of such termination; provided, however, that the Parties will work collaboratively to arrange alternative placement and to provide for uninterrupted care of existing Hospice Patients in Nursing Home. Reimbursement for services for provided by Nursing Home upon termination shall continue as provided herein until the Hospice Patient revokes his/her Medicare/Medicaid Hospice election, or until the Hospice Patient elects to use another Hospice Provider.

VIII.
GENERAL PROVISIONS

1. Notices. Any notice, demand, or communication required, permitted, or desired to be given hereunder, shall be deemed effectively given when personally delivered or mailed by prepaid certified mail, return receipt requested, or overnight carrier addressed as follows:

To Nursing Home: ______________________________

To Hospice: HERITAGE HOSPICE, LLC

or to such other address, and to the attention of such other persons or officers as either Party may designate by advance written notice. Notice will be deemed given upon receipt.

2. Insurance. Each Party shall, at such Party's sole cost and expense, procure, keep and maintain throughout the term of the Agreement, insurance coverage in the minimum amounts of $1,000,000 per occurrence and $3,000,000 annual aggregate for commercial general liability; $1,000,000 per occurrence and $3,000,000 annual aggregate for professional liability; With respect to the general liability insurance, Hospice shall name Nursing Home as additional insured on a primary and noncontributory basis with waiver of subrogation; $1,000,000 each and every occurrence for automobile liability; and applicable state statutory limits for workers' compensation, and issued by an insurer acceptable to the other Party. In addition to the coverages specifically listed herein, each Party shall maintain any other usual and customary policies of insurance applicable to the work being performed pursuant to the Agreement. Such policy(ies) shall cover all of such Party's Services provided hereunder. By requiring insurance herein, neither Party represents that coverage and limits will necessarily be adequate to protect the other Party, and such coverage and limits shall not be deemed as a limitation on a Party's liability under the indemnities granted to the other Party in the Agreement. In the event a Party procures a "claims-made" policy to meet the insurance requirements herein, such Party agrees to purchase "tail" coverage upon the termination of any such policy or upon termination of the Agreement with an indefinite reporting

period. Each Party will furnish to the other Party at least annually a certificate of insurance evidencing all of the policies of insurance required herein.

3. Indemnification.

    1. Nursing Home shall defend, indemnify and hold harmless Hospice, its officers, directors, employees and agents from and against all claims, liabilities, losses, damages, costs or expenses of any kind (including reasonable attorneys' fees) arising directly or indirectly out of the (i) breach of any material term of this Agreement or (ii) acts or omissions of Nursing Home, its employees and agents.

    2. Hospice shall defend, indemnify and hold harmless Nursing Home, its officers, directors, employees and agents from and against all claims, liabilities, losses, damages, costs or expenses of any kind (including reasonable actual attorneys' fees) arising directly or indirectly out of the (i) breach of any material term of this Agreement or (ii) acts or omissions of Hospice, its employees and agents.

    3. An indemnitee entitled to indemnification under this Section shall give notice to the indemnitor of a claim or other circumstances likely to give rise to a request for indemnification promptly after the indemnitee becomes aware of the same.

4. Entire Agreement. This Agreement, including the exhibits, constitutes the entire agreement between the Parties with respect to the subject matter hereof. This Agreement supersedes all previous agreements between or among the Parties with regard to the subject matter described herein. There are no agreements, representations, or warranties between or among the Parties other than those set forth in this Agreement or documents or agreements referred to in this Agreement.

5. Jeopardy. Notwithstanding anything to the contrary herein contained, in the event the performance of either Party of any term, covenant, condition or provision of the Agreement jeopardizes the licensure of Hospice or Nursing Home, as applicable, its payment or reimbursement from Medicare, Medicaid, Blue Cross or other reimbursement or payment programs, or, if applicable, the tax-exempt status of a Party or any of its Affiliates, or will prevent or prohibit any physician or any other health care professionals or their patients from utilizing Hospice or Nursing Home for any of their services, or if for any other reason, a Party's performance under this Agreement violates any statute, ordinance, regulation or accreditation standard governing a Party, either Party may, at its option, initiate negotiations to resolve the matter through amendments to the Agreement and, if the Parties are unable to resolve the matter within thirty (30) days thereafter, either Party may, at its option, terminate the Agreement immediately.

6. Non-Disclosure of Information. Nursing Home agrees, with respect to all proprietary information that is or has been furnished or disclosed by Hospice or that is or has been developed by Nursing Home for Hospice, including, but not limited to, information regarding Hospice's organization, personnel, programs, business activities, policies, procedures, patients, rights,

obligations, liabilities and strategies ("Information"), that, (i) such Information is confidential and/or proprietary to Hospice and is entitled to and shall receive treatment as such by Nursing Home; (ii) Nursing Home will hold in confidence and will not disclose nor use any such Information, treating such Information with the same degree of care and confidentiality as it affords its own confidential and proprietary information; and (iii) all such information furnished to Nursing Home by Hospice, unless otherwise specified in writing, shall remain the property of Hospice and, in the event this Agreement is terminated, shall be returned to Hospice, together with any and all copies made thereof, and together with oral Information furnished to Nursing Home which shall have been reduced to writing. In the event of Nursing Home's actual or threatened breach of this paragraph, Hospice shall be entitled to a preliminary restraining order and injunction restraining Nursing Home from violating its provisions. Nothing in the Agreement shall be construed to prohibit Hospice from pursuing any other available remedies for such breach or threatened breach, including the recovery of damages from Nursing Home.

7. Independent Contractor. It is expressly acknowledged by the Parties hereto that Nursing Home and Hospice and their Personnel providing services hereunder are independent contractors, and nothing in the Agreement is intended, nor shall be construed, to create between Hospice and Nursing Home an employer/employee relationship, a joint venture relationship, or a lease or landlord/tenant relationship, or to allow either Party to exercise control or direction over the manner or method by which the other Party furnishes the Services which are the subject matter of this Agreement.

8. Access to Records. To the extent required by 42 U.S.C. § 1395x(v)(1)(i) until the expiration of four (4) years after the termination or expiration of the Agreement, Nursing Home shall make available, upon written request to the Secretary of the Department of Health and Human Services, or the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of the Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the goods or services provided by Nursing Home under the Agreement. Nursing Home further agrees that, in the event Nursing Home carries out any of its duties under the Agreement through a subcontract with a related organization with a value or cost of Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period, such subcontract shall contain a provision requiring the related organization to comply with the with the requirements of this Section.

9. Compliance with Medicare Anti-Kickback, Self-Referral and Anti-Rebate Laws. Neither Party shall engage in any activity prohibited by 42 U.S.C. § 1395nn (42 Code of Federal Regulations, Part 411 (411.1 to 411.361)), 42 U.S.C. § 1320a-7a and 42 U.S.C. § 1320a-7b (42 Code of Federal Regulations, Part 1001 (1001.952(a) to 1001.1001)) or any other federal state or local law or regulation relating to the referral of patients, including, without limitation, anti-kickback and self-referral prohibitions and limitations, as those laws or regulations now exist or as subsequently revised.

10. HIPAA. Each Party acknowledges that it is a Covered Entity under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as amended from time to time, including 45 C.F.R. Parts 160, 162 and 164 and the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations, as amended from

time to time ("HIPAA"). Each Party shall comply, and shall require that their respective agents, employees and contractors shall comply, with HIPAA.

11. No Referral Obligation. Nothing contained in this Agreement shall be construed as a promise or inducement for either Party to make a referral to the other. The Parties agree that the financial terms of this Agreement are fair market value for the Nursing Home Services provided by Nursing Home under this Agreement, are a result of bona fide and arms-length negotiations, and are not based in any manner upon the volume or value of referrals or other business between the Parties.

12. Assignment. Except as otherwise expressly provided herein, neither Party may assign any of its rights or obligations under the Agreement without the prior written consent of the other Party; provided, however, that Hospice may assign its rights and duties to an Affiliate.

13. Amendments. The Agreement may be amended at any time by mutual agreement of the Parties, provided that, before any amendment shall become effective, it shall be reduced to writing and signed by each of the Parties.

14. No Third Party Beneficiaries. There are no third party beneficiaries to the Agreement.

15. Compliance. Nursing Home acknowledges that it agrees to be bound by and comply with all policies and procedures set forth in Hospice's Compliance Program. In furtherance of the foregoing, Nursing Home shall immediately notify Hospice of: (i) any and all possible instances of non-compliance on the part of Hospice or any of its employees or agents of which Nursing Home is aware; (ii) any subpoena or other request for information or other documents relative to the Nursing Home Services rendered hereunder; or (iii) any action taken to exclude Nursing Home from participation in Medicare, Medicaid or other governmental payment programs.

16. Binding Effect. This Agreement shall be binding upon the Parties hereto, their permitted successors and assigns.

17. Governing Law. The Agreement shall be governed by and construed in accordance with the laws of the State in which Hospice is located, applicable to agreements made and to be performed within that state, irrespective of such state's choice-of-law principles.

18. Partial Invalidity. If any provision of the Agreement is found to be invalid or unenforceable by any court or other lawful forum, such provision shall be ineffective only to the extent that it is in contravention of applicable laws without invalidating the remaining provision of the Agreement, unless such invalidity or unenforceability would defeat an essential business purpose of the Agreement.

19. Cumulation of Remedies. The various rights, options, elections, powers and remedies of the Parties contained in, granted or reserved by the Agreement, are in addition to any others that the Parties may be entitled to by law, shall be construed as cumulative, and no one of them is exclusive of any of the others, or of any right or priority allowed by law.

20. Waiver. No waiver or failure by any Party to enforce any of the terms, conditions, provisions, or obligations herein shall be construed as a waiver of any subsequent breach of such

provision, term, condition or obligation, or obligation hereunder, whether the same or different in nature. No extension of time for performance of any of the obligations or acts shall be deemed an extension of time for performance of any other obligations or acts.

21. Counterparts. This Agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the Parties have executed this Agreement to be effective as of the Effective Date.

HOSPICE:	**NURSING HOME:**
HERITAGE HOSPICE, LLC	______________________________
By:______________________________	By: ______________________________
Name: ______________________________	Name:
Title: Executive Director	Title: Administrator

EXHIBIT A

HOSPICE ADMISSION CRITERIA

Hospice will provide Facility with a copy of its applicable policies and procedures upon execution of this Agreement. Hospice reserves the right to alter or amend such policies and procedures from time to time, at the discretion of Hospice, and will notify Facility of any such change(s). Hospice will provide Facility with training and orientation on its standards of practice.

EXHIBIT B

REQUEST FOR THE PROVISION OF HOSPICE HOME CARE SERVICES TO A NURSING HOME RESIDENT

Please see attached request for provision of hospice services form.

EXHIBIT C

NURSING HOME ADMISSION POLICY

Nursing Home will provide Hospice with a copy of its applicable policies and procedures upon execution of this Agreement, and will notify Hospice of any change(s).

EXHIBIT D

SERVICES AND ITEMS TO BE FURNISHED TO HOSPICE BY NURSING HOME

All Purchased Ancillary Services must be related to the Hospice Patient's terminal illness and included in the Hospice Plan of Care. Facility agrees that Hospice has the option to use its own vendors for purchased services for the provision of prescription medications and pharmaceuticals, equipment, supplies and other ancillaries. In order for services to be billed by Facility and paid by Hospice, Purchased Ancillary Services must be pre-authorized by Hospice at agreed upon rates. Items will be listed on the request for Provision of Hospice Services Form and given to Facility billing office.

EXHIBIT E

COMPENSATION AND BILLING

I. ROOM AND BOARD

A. Medicaid

For Hospice Patients who are Medicaid beneficiaries, Hospice will reimburse Facility at 100% of the Facility's Medicaid per diem rate for Facility Room and Board Services. For services and items related to the Hospice Patient's terminal illness, Facility will bill Hospice in accordance with the terms of this Agreement.

For Hospice Patients who are not under a current election of the Medicaid Hospice Benefit, Facility Room and Board fees are strictly between the Facility and the Hospice Patient unless a third-party payor includes Room and Board as part of its Hospice benefit payable to Hospice. Hospice has no responsibility for Room and Board fees for a Medicare-only eligible Hospice Patient.

Upon receipt of a Medicaid-eligible Hospice Patient's Patient Liability Amount to be collected by Facility, Facility will reimburse the Hospice Patient his/her monthly living allowance, applying the balance to the Hospice Patient's per diem rate at Facility, offsetting the amount payable from Hospice. For Medicaid-eligible Hospice Patients, Facility also agrees to bill Hospice for any Purchased Ancillary Services provided, as delineated in Exhibit D, which are related to Hospice Patient's terminal illness and to accept such payment as payment in full.

B. Commercial Third-Party Insurance

If Hospice Patient is eligible for third-party payor coverage for Hospice Services, Hospice will reimburse Facility a mutually agreed upon rate for the room and board portion of the services provided. Facility will bill Hospice for Purchased Hospice Services in accordance with this Agreement.

II. RESPITE CARE

A. Medicare/ Medicaid

Hospice shall pay Nursing Home for Respite Care rendered to Medicare/ Medicaid Hospice Patients at $______per day for up to five (5) consecutive days. Hospice shall pay Nursing Home within 30 days of receipt of an invoice from Nursing Home in a form and containing such information reasonably requested by Hospice. The rate described herein shall be an all inclusive rate and shall cover all terminal medications, medical supplies, durable medical equipment, therapies and room and board. Hospice shall be responsible for collecting co-payment amounts for Respite Care Services. Nursing Home shall invoice Hospice directly for Respite Care provided to Hospice Patients, and shall not seek payment from any Hospice Patient or other party. Nursing Home shall submit such invoices to Hospice no later than the last day of the month following the month in which Respite Care was provided. Hospice shall have the sole right to bill and collect from Medicare for Respite Care provided by Nursing Home under the Agreement.

B. Commercial Third-Party Insurance

If Hospice Patient is eligible for third-party payor coverage for Hospice Services, Hospice will reimburse Facility a mutually agreed upon rate for the Respite Care portion of the services provided. Facility will bill Hospice for Purchased Hospice Services in accordance with this Agreement.

III. GENERAL INPATIENT CARE

A. Medicare/ Medicaid

Hospice shall pay Nursing Home for General Inpatient Care rendered to Medicare/ Medicaid Hospice Patients at a rate of $______ per day, within 30 days of receipt of an invoice from Nursing Home in a form and containing such information reasonably requested by Hospice. Such rate shall be inclusive of all nursing services, all terminal related medications, medical supplies, durable medical equipment, therapies, and room and board related services. Nursing Home shall invoice Hospice directly for General Inpatient Care provided to Hospice Patients, and shall not seek payment from any Hospice Patient or other party. Nursing Home shall submit such invoices to Hospice no later than the last day of the month following the month in which General Inpatient Care was provided. Hospice shall have the sole right to bill and collect from Medicare for General Inpatient Care provided by Nursing Home under the Agreement.

B. Commercial Third-Party Insurance

If Hospice Patient is eligible for third-party payor coverage for Hospice Services, Hospice will reimburse Facility a mutually agreed upon rate for the General Inpatient portion of the services provided. Facility will bill Hospice for Purchased Hospice Services in accordance with this Agreement.

SUPPLEMENTAL ATTACHMENT

Hospice Agency Form

Attachment - Home Care Organizations

Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	X	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	X	McMinn	☐	☐	X
Campbell	☐	☐	☐	McNairy	☐	☐	☐
Cannon	☐	☐	☐	Macon	☐	☐	☐
Carroll	☐	☐	☐	Madison	☐	☐	☐
Carter	☐	☐	☐	Marion	☐	☐	X
Cheatham	☐	☐	☐	Marshall	☐	☐	☐
Chester	☐	☐	☐	Maury	☐	☐	☐
Claiborne	☐	☐	☐	Meigs	☐	☐	X
Clay	☐	☐	☐	Monroe	☐	☐	X
Cocke	☐	☐	☐	Montgomery	☐	☐	☐
Coffee	☐	☐	☐	Moore	☐	☐	☐
Crockett	☐	☐	☐	Morgan	☐	☐	☐
Cumberland	☐	☐	☐	Obion	☐	☐	☐
Davidson	☐	☐	☐	Overton	☐	☐	☐
Decatur	☐	☐	☐	Perry	☐	☐	☐
DeKalb	☐	☐	☐	Pickett	☐	☐	☐
Dickson	☐	☐	☐	Polk	☐	☐	X
Dyer	☐	☐	☐	Putnam	☐	☐	☐
Fayette	☐	☐	☐	Rhea	☐	☐	X
Fentress	☐	☐	☐	Roane	☐	☐	☐
Franklin	☐	☐	☐	Robertson	☐	☐	☐
Gibson	☐	☐	☐	Rutherford	☐	☐	☐
Giles	☐	☐	☐	Scott	☐	☐	☐
Grainger	☐	☐	☐	Sequatchie	☐	☐	X
Greene	☐	☐	☐	Sevier	☐	☐	☐
Grundy	☐	☐	☐	Shelby	☐	☐	☐
Hamblen	☐	☐	☐	Smith	☐	☐	☐
Hamilton	☐	X	X	Stewart	☐	☐	☐
Hancock	☐	☐	☐	Sullivan	☐	☐	☐
Hardeman	☐	☐	☐	Sumner	☐	☐	☐
Hardin	☐	☐	☐	Tipton	☐	☐	☐
Hawkins	☐	☐	☐	Trousdale	☐	☐	☐
Haywood	☐	☐	☐	Unicoi	☐	☐	☐
Henderson	☐	☐	☐	Union	☐	☐	☐
Henry	☐	☐	☐	Van Buren	☐	☐	☐
Hickman	☐	☐	☐	Warren	☐	☐	☐
Houston	☐	☐	☐	Washington	☐	☐	☐
Humphreys	☐	☐	☐	Wayne	☐	☐	☐
Jackson	☐	☐	☐	Weakley	☐	☐	☐
Jefferson	☐	☐	☐	White	☐	☐	☐
Johnson	☐	☐	☐	Williamson	☐	☐	☐
Knox	☐	☐	☐	Wilson	☐	☐	☐
Lake	☐	☐	☐				