HEALTH FACILITIES COMMISSION
AUGUST 28, 2024
APPLICATION REVIEW

NAME OF PROJECT:	Shalom Hospice of Southeast Tennessee, LLC
PROJECT NUMBER:	CN2406-016
ADDRESS:	1200 Premier Drive, Suite 210 Chattanooga (Hamilton County), TN 37421
LEGAL OWNER:	Sam Stern and SYGS 2023 Trust 135 Lakeside Drive East Lawrence (Nassau County), NY 11559
OPERATING ENTITY:	N/A
CONTACT PERSON:	Michael Brent, Attorney Bradley, Arant, Boult, Cummings (615) 252-2361
DATE FILED:	July 1, 2024
PROJECT COST:	$500,000
PURPOSE FOR FILING:	Establishment of a home care organization and the initiation of in-home hospice services.

Staff Review

Note to Commission members: This staff review is an analysis of the statutory criteria of Need, Consumer Advantage Attributed to Competition, and Quality Standards, including data verification of the original application and, if applicable, supplemental responses submitted by the applicant. Any Health Facilities Commission Staff comments will be presented as a "Note to Commission members" in bold italic.

PROJECT DESCRIPTION:
This application is for the establishment of a new home care organization and the initiation of in-home hospice services with a parent office located at 1200 Premier Drive, Suite 210, Chattanooga (Hamilton County), Tennessee 37421. The proposed service area will consist of Hamilton, Marion, Sequatchie, Bradley, and Polk Counties.

Executive Summary

- If approved, the applicant projects the proposed project will open for service in December 2024.
- The applicant proposes to establish a new hospice agency focused on serving terminally ill individuals of the Jewish faith residing in Hamilton, Bradley, Marion, Polk and Sequatchie Counties in Tennessee.
- The proposed in-home hospice agency will be newly formed and owned by the same ownership group which operates affiliate agencies: Shalom Hospice, LLC, (license #626) serving Davidson, Rutherford, and Williamson Counties in Middle TN; and Shalom Hospice of Greater Knoxville, LLC (license #629) serving Anderson, Blount, Jefferson, Knox, Loudon, and Sevier Counties in East TN. Both of these affiliate agencies provide a focus of serving the Jewish population.
- The applicant will be separately licensed from its other hospice agencies in Tennessee, which are based in Williamson County and Knox County. The applicant operates twenty-seven other affiliate hospice agencies in twelve other states under the name Affinity Care or Continuum Care.
- The applicant states that the proposed service area area is home to approximately 3,000 to 4,000 Jewish residents with no hospice agencies currently providing end of life programming specific to this population.
- The applicant states that the percentage of patients who are Jewish at its newly established affiliate hospice agency, Shalom Hospice of Greater Knoxville, is approximately (20%), which represents an increase from (15%) in its first month of Medicare certification. The applicant projects that at least (20%) of its hospice admissions to the newly proposed facility will be for Jewish residents.
- The applicant will offer all four levels of hospice care: Routine Home Care, General Inpatient Care, Continuous Home Care, and Respite Care.
- The applicant anticipates providing care in the settings listed below:

Location of Care	Yes	No	% of Patients
Home	X		40%
Assisted Living Facility	X		22%
Nursing Facility	X		<1%
Skilled Nursing Facility	X		35%
Inpatient Hospital Facility	X		1%
Other (group homes, shelters, etc.)	X		2%

- Please see application Item 1E. on Pages 6 & 7 for the applicant's executive summary overview that includes project description, ownership, service area, existing similar service providers, project cost, and staffing.

Note to Agency members: The applicant states the while the hospice agency will have a specific emphasis on serving persons of Jewish faith, it will not discriminate against members of any religion (or any other protected class).

Consent Calendar: ☐ Yes √ No

- Executive Director's Consent Memo Attached: ☐ Yes √ Not applicable

Facility Information

- The proposed home office for the applicant will utilize approximately 2,425 square feet of space at its Chattanooga office location. No patient care will be provided on the premises.
- The project site will be leased from the owner, 1200 Pointe Centre Partners, GP, to Shalom Hospice of Southeast Tennessee, GP, for an initial 63-month lease term. See Attachments 9A – Lease Agreement and 10A Floor Plan.

Ownership

- The applicant, Shalom Hospice, LLC is owned and managed by The SYGS 2023 Trust (95%) and Samuel Stern (5%).

Project Cost Chart

- The total project cost is $500,000. Of this amount, the highest line-item costs of the project are Building Lease Costs ($287,000), Legal, Administrative and Consultant Fees ($75,000), and Office Furniture and Technology ($75,000).
- For additional information, please refer to the Project Cost Chart on Page 10 of the original application.

NEED

The applicant provided the following supporting the need for the proposed project**:**

- Lack of existing hospice services providers that are familiar with Jewish customs and rituals, specifically related to end of life. The applicant highlights the fact that no existing service area providers are accredited by the National Institute for Jewish Hospice (NIJH).
- The need to introduce a level of service that extends beyond what is currently available in this market through the implementation of a music therapy program, virtual reality program and equine therapy programs.
- The applicant provides letters of support from physicians, providers, nursing homes, assisted living facilities, and home health providers (16), Jewish congregations and religious affiliated organizations (8), and service area residents (2) in the service area advocating the need for a hospice provider that recognizes the heritage, history, and traditions of the Jewish patients. See Attachment 1N-2.

(For applicant discussion, see the Original Application, Item 2.E., Pages 8 & 9)

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

Hospice Services:
All applicable criteria and standards were met except for the following:

- Did not meet the standard of **#17. Need Formula: "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 Statewide Median Hospice Penetration Rate (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) if 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."** *This project proposes to initiate hospice services in a five-county service area – Bradley, Hamilton, Marion, Polk, and Sequatchie Counties, which cumulatively show a surplus capacity of (2,542) hospice admissions according to the standard of 80% of the Statewide Median Hospice Penetration Rate (SMHPR). Individually, each of the five counties show a Statewide Median Hospice Penetration Rate above 80%: Hamilton County (1,959), Bradley County (343), Marion County (106), Sequatchie County (92), and Polk County (42). The applicant requests special consideration for approval outside of the Need Formula based upon its targeting of the specialized needs of a specific underserved population – Jewish people of the Southeastern Tennessee area. Letters of support related to need in the service area are provided by the applicant in Attachment 1N-2.* ***See Attachment 1.N. Hospice Services Standards and Criteria, Pages 49-56.***

  Please see attached for a full listing of the criteria and standards and the applicant's responses.

Service Area Demographics

- The proposed service area consists of Bradley, Hamilton, Marion, Polk, and Sequatchie Counties (*see Attachment 2N for a county level map*).
- The target population is the adult population age 65 and older. (*See Pages 16 - 21 for more demographic detail.*)

County	2024 Population	2028 Population	2024 Population 65+	2028 Population 65+	% Change 65+	Median Household Income	% of Persons Below Poverty Level	TennCare %
Bradley County	112,767	116,171	21,740	23,790	9.4%	$60,692	13.1%	21.6%
Hamilton County	383,109	393,234	75,214	80,749	7.4%	$69,069	11.8%	18.2%
Marion County	28,886	28,750	6,518	6,865	5.3%	$58,139	13.9%	24.0%
Polk County	17,159	17,410	3,983	4,338	8.9%	$53,775	15.4%	23.3%
Sequatchie County	15,754	16,256	3,756	4,111	9.5%	$53,038	17.5%	25.4%
Service Area Total	**557,675**	**571,821**	**111,211**	**119,853**	**7.8%**		**12.4%**	**19.5%**
Tennessee Total	**7,125,908**	**7,331,859**	**1,324,362**	**1,438,845**	**8.6%**	**$64,035**	**13.3%**	**21.2%**

Source: CN2406-016, Attachment 3N, The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

- The proposed service area projects a 4-year growth rate (2024-2028) among residents age 65+ and over of (7.8%) which is lower than the statewide rate of (8.6%).
- The latest 2024 percentage of (19.5%) of service area residents enrolled in the TennCare program is lower than the (25.0%) statewide average. One of the five proposed service area counties, Hamilton County, has a lower TennCare program enrollment rate (18.2%) than the statewide average.
- Please see Item 4N., Pages 22-27 in the application for special needs of the service area population including health disparities.
- Attachment 1N-17 includes additional documentation of the special needs of the service area population including the following: 1) "Jewish Ritual, Reality and Response at the End of Life: A Guide to Caring for Jewish Patients and Their Families"; 2) Information on Chayim Aruchim which is resource to assist the Jewish community in making end of life health care decisions, and 3) A copy of the Halachic Medical Directive – Tennessee, which is designed to help ensure that all medical and post-death decisions made by others on patients behalf will be made in accordance with Jewish law and custom.
- The applicant identifies three strategies that it plans to implement to address the needs of the target population including the following:
    1. The applicant will become accredited through the National Institute for Jewish Hospice (NIJH).
    2. Employment of a rabbi to serve as a chaplain to the hospice team.
    3. Working with the Jewish Cultural Center, Jewish Federation and with local rabbis to sponsor quarterly community education events and workshops at

area community centers and congregations regarding the benefits of hospice services.
4. Hiring a Jewish services coordinator to respond to patient needs.
5. Development of a bereavement program designed to meet the needs of Jewish patients.
6. Development of a virtual reality platform that honors the history and plight of the Jewish experience and virtual travel to religious sites for Jewish patients.

Note to Commission members: The applicant provides the following explanation of Chayim Aruchim and the Halachic Medical Directive (See Supplemental #1, Question #10, Page 5: "The Halachic Medical Directive is published by Chayim Aruchim, which is an organization distinct from NIJH. Chayim Aruchim's mission is dedicated to helping members of the Jewish community make end-of-life healthcare decisions in keeping with their religious beliefs. Chayim Aruchim has a team of medically trained Rabbis, doctors, legal experts, patient and pastoral care professionals. Shalom Hospice ascribes to Chayim Aruchim as part of its operation incorporating its recommendations and medical directive into its processes. Chayim Aruchim is voluntary and not a requirement of the NIJH accreditation."

Service Area- Historical Utilization (In-Home Hospice Agencies)

- Utilization for the (9) licensed in-home hospice agencies from 2021-2023 operating in the five-county service area is detailed in the table below:

Utilization of Service Area In-Home Hospice Agencies 2021-2023

Hospice Agency	State ID	2021	2022	2023	Total Patients 2021-2023	% Change in Patients 2021-2023	% Change 2021-2023
Adoration Home Health and Hospice Care East TN	06063	199	637	307	1,143	7.1%	54.3%
Kindred Hospice	06603	267	214	188	669	4.2%	-29.6%
Avalon Hospice	19694	213	234	152	599	3.7%	-28.6%
Amedisys Hospice and Adventa Co.	33603	503	810	700	2,013	12.5%	39.2%
Gentiva	33643	25	15	23	63	0.4%	-8.0%
Caris Healthcare	33653	90	74	96	260	1.6%	6.7%
Hearth Hospice of Tennessee	33673	1,237	1,299	1,521	4,057	25.2%	23.0%
Hospice of Chattanooga Inc.	33613	2,836	1,973	2,464	7,273	45.2%	-13.1%
Amedisys Hospice and Adventa Co.	47602	0	0	5	5	0%	NA
Total, Licensed Hospice Agency Patients		**5,370**	**5,256**	**5,456**	**16,082**	**100%**	**1.6%**

Source: CN2406-016, Application, Page 29

- From 2021-2023 five of the nine hospice agencies represented (98.0%) of the total volume of hospice patients residing in the service area.

- The three highest volume providers were Hospice of Chattanooga Inc. – ID 33613 (7,273 patients served – 45.2% of total patients from the service area); Hearth Hospice of Tennessee – ID 33673 (4,057 patients served – 25.2% of total patients from the service area); and Amedisys Hospice and Adventa Co. – ID 33603 (2,013 patients served – 12.5% of total patients from the service area).
- The number of patients receiving hospice services has increased by (1.6%) from 2021-2023.

Utilization of Service Area In-Home Hospice Agencies by County of Residence 2023

Hospice Agency	State ID	Bradley	Hamilton	Marion	Polk	Sequatchie	2023 Total Patients
Adoration Home Health and Hospice Care East TN	06063	83	154	38	21	11	307
Kindred Hospice	06603	52	128	NL	8	NL	188
Avalon Hospice	19694	2	129	18	0	3	152
Amedisys Hospice and Adventa Co.	33603	77	502	48	47	26	700
Gentiva	33643	0	22	1	0	0	23
Caris Healthcare	33653	25	42	3	13	13	96
Hearth Hospice of Tennessee	33673	293	1,114	56	32	26	1,521
Hospice of Chattanooga Inc.	33613	388	1,825	123	51	77	2,464
Amedisys Hospice and Adventa Co.	47602	0	4	NL	1	0	5
Total, Licensed Hospice Agency Patients		**920**	**3,920**	**287**	**173**	**156**	**5,456**

Source: CN2406-016, Attachment 3NR, Page 29R

- The largest number of hospice patients were served in Hamilton County in 2023 (3,920) followed by Bradley County (920) and Marion County (287).

Applicant's Historical and Projected Utilization

There is no historical utilization for the applicant. The following table indicates the applicant's projected hospice utilization by number of cases in Year 1 (2025).

Projected Utilization – Shalom Hospice of Southeast Tennessee, LLC

Service Area County	Projected Utilization Year 1 (2025)	Total Cases
Hamilton	49	62%
Bradley	16	20%
Marion	6	8%
Polk	4	5%
Sequatchie	4	5%
Total	**79**	**100%**

Source: CN2406-016, Application, Page 12

- The applicant projects that (82%) of patient utilization will originate from Hamilton County and Bradley County combined.

Projected Utilization – Shalom Hospice of Southeast Tennessee, LLC

	Year 1 (2025)	Year 2 (2026)
Admissions	79	156
Average Length of Stay - ALOS (Days)	42.8	65.6
Patient Days	3,379	10,235

Source: CN2406-016, Attachment 6N, Page 36

- The applicant is projecting an increase in average length of stay for patients from 42.8 days in Year 1 (2025) to 65.6 days in Year 2 (2026).
- The applicant expects the average length of stay to increase based upon historical experience initiating new hospice agencies as well as the following considerations:
  1. Patients in Year 1 being referred at a later point than will be the case in Year 2, once the agency has been fully established resulting in a shorter stay for many patients.
  2. The percentage of patients who maximize the hospice benefit is projected to increase over time.

CONSUMER ADVANTAGE ATTRIBUTED TO COMPETITION

Charges

- The applicant's proposed charges are listed on Page 19. The applicant's unit of measure for calculating charge information is patient days.

	Projected Data Chart	
	Year 1	Year 2
Gross Charges	$194.81	$197.73
Deduction from Revenue	$16.30	$10.88
Average Net Charges	$178.51	$186.86

Source: CN2406-016, Application, Page 19.

- The applicant's average net charges are projected to increase by (4.7%) from Year 1 to year 2 of the project.
- The applicant provides a comparison between its proposed Net Revenue per Patient Day compared to other licensed agencies in the service area on Page 39 of the application.

2023 Comparison of Licensed Hospice Agencies in the Project Service Area
Medicare Per Diem Rates by Service Category

Hospice Agency	State ID	Routine Home Care	Continuous Home Care	General Inpatient Care	Respite Care
Adoration Home Health and Hospice Care East TN	06063	$203	$1,463	$1,068	$474
Kindred Hospice	06603	$183	$1,293	$970	$432
Avalon Hospice	19694	$193	$1,368	$1,016	$452
Amedisys Hospice and Adventa Co.	33603	$153	$500	$825	$409
Gentiva	33643	$190	$1,343	$1,001	$445
Caris Healthcare	33653	$190	$1,343	$1,001	$445
Hearth Hospice of Tennessee	33673	$158	$1,251	$996	$434
Hospice of Chattanooga Inc.	33613	$158	$1,396	$990	$445
Amedisys Hospice and Adventa Co.	47602	$139	$500	$909	$383
Average of Licensed Hospice Agency Patients		$174	$1,162	$975	$435
Shalom Hospice of Southeast Tennessee, LLC FY2024		**$156-198**	**$58/hr**	**$1,043**	**$465**

Source: CN2406-016, Application, Page 20

- The applicant has projected a range for its Net Revenue per Patient Day for Routine Home Care in Year One of ($156-$198) which it states are based on an average of $183.40 before pre Medicare write offs and $178.51 including those write offs.

Project Payor Mix

	Percentage of Gross Operating Revenue						
	Medicare	**Medicaid**	**Commercial**	**Self-Pay**	**Other**	**Total**	**Charity Care**
Year 1	89%	8%	2%	1%	0%	**100%**	3%

Source: CN2406-016, Application, Page 21

- Please refer to Item 10C. in the Consumer Advantage section of the application for specific Payor Mix information.
- A full list of in-network payors is included as Item 2.C.

Agreements

- The applicant 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 has included a sample hospice services contract for general inpatient and respite care with a skilled nursing facility as Attachment 1C.
- The applicant states that it intends to contract with all Managed Care Organizations (MCOs) serving the area including WellPoint (formerly Amerigroup), BlueCare, UnitedHealthcare Community Plan, and TennCare Select.

Staffing

- The applicant's Year One proposed staffing includes the following:

	Year One
Direct Patient Care Positions	9.3
Non-Patient Care Positions	3.0
Contractual Staff	0.2
Total	**12.5**

Source: CN2406-016, Application, Page 25.

- Direct Care positions includes the following: Clinical Director (1.0 FTE); Registered Nurse (2.0 FTEs); Aides (1.8 FTEs); Social Worker (1.0 FTE); Chaplain (1.0 FTE); Music Therapist (0.5 FTE); Bereavement Coordinator (1.0 FTE); and On-Call Nurse (RN) (1.0 FTE).
- Non-Patient Care positions includes the following: Administrator (1.0 FTE); Office Assistant (1.0 FTEs); Hospice Liaisons (1.0 FTEs).
- A Medical Director will be contracted at (0.2 FTE).
- Please refer to Item 8Q. on Page 25 of the application for additional detail regarding project staffing.
- The applicant states that its staffing plan will exceed the general staffing requirements and qualifications of the National Hospice and Palliative Care Organization (NHPCO).
- The applicant highlights it proposed staffing ratios for the following patient care positions:
    - 2 Registered Nurses (ratio of 1:10) including a part time floater,
    - 1.8 hospice aides (ratio of 1:8),
    - 1 social worker (ratio of 1:25),
    - 1 chaplain (to be an ordained rabbi, a ratio of 1:25),
    - 0.5 FTE for music therapy (a ratio of 1:50),
    - 1 bereavement coordinator and 1 on-call nurse (ratio of 1:50).
- The applicant states that it will staff a volunteer coordinator once its average daily census reaches 40; prior to that the office assistant assumes that role.
- The applicant will have a nutritionist/dietician available through a contracted position in accordance with Medicare Conditions of Participation.
- The applicant states that it has not yet identified a Medical Director but it plans to contract with a service area physician.
- For additional detail regarding the applicant's strategy for staffing the project and the availability of Registered Nurses in the service area see Item 4C. on Pages 41R-42.

Comparison of Hospice Aide Staffing for Service Area Providers 2023

Agency	Home County	Patient Days	Average Daily Census	Aides, Full Time	Aides, Part Time	Aides, Total (FT + 50% PT)	Ratios of Patients per Aide
Home Health Care of East Tennessee, Inc.	Bradley	73,878	202.4	10.0	0.0	10.0	20.2
Kindred Hospice	Bradley	25,926	71.0	6.0	0.0	6.0	11.8
Avalon Hospice	Davidson	546,515	1,497.3	117.0	0.0	117.0	12.8
Amedisys Hospice and Adventa Company	Hamilton	118,162	323.7	17.0	2.0	18.0	18.0
Gentiva Hospice	Hamilton	1,653	4.5	0.0	0.0	0.0	NA
Caris Healthcare	Hamilton	28,039	76.8	4.0	1.0	4.5	17.1
Hearth Hospice	Hamilton	113,265	310.3	18.0	0.5	18.3	17.0
Hospice of Chattanooga Holdings, LLC	Hamilton	102,281	280.2	17.0	1.5	17.8	15.8
Amedisys Hospice and Adventa Company	Knox	313,327	858.4	31.0	8.0	35.0	24.5
Service Area Providers, Total		1,323,046	3,624.8	220.0	13.0	226.5	16.0
Shalom Hospice of Southeast Tennessee	Hamilton	10,235	28.0	3.5	0.0	3.5	8.0

Source: CN2406-016, Attachment 1N, Pages 37.

- The applicant provides detail regarding its proposed ratio of 8 patients per Home Health Aide staffing plan compared to its affiliate agencies below (See Supplemental #1, Question #11, Page 6:

  "Through experience, Affinity has developed staffing metrics which meet the needs of its patients, maintaining them on the routine level of care, and avoiding unnecessary crisis care. These ratios have a positive effect on quality of care and cost effectiveness as they avoid more costly care. The ratio of 8 patients per hospice aide ratio is one of these staffing metrics. Specifically, with respect to 8 patients per aide ratio, it is the Affinity programming model to staff to that level to achieve the service intensity it promotes and utilizes throughout the company to assure daily touches with its patients. And, within both the Middle Tennessee and the Greater Knoxville area, the two Shalom affiliates are also staffing to that level."

QUALITY STANDARDS

- The applicant commits to obtaining and/or maintaining the following:

Licensure	Certification	Accreditation
Health Facilities Commission	Medicare/ TennCare	Community Health Accreditation Partner (CHAP) National Institute for Jewish Hospice Accreditation (NIJH)

Source: CN2406-016, Application, Page 23.

- The applicant will apply for Licensure through the Tennessee Health Facilities Commission, Certification through Medicare and TennCare, and accreditation through Community Health Accreditation Partner (CHAP) and The National Institute for Jewish Hospice (NIJH). The applicant anticipates that CHAP Accreditation will be obtained within 60 days of licensure.
- In addition to NIJH and CHAP accreditation, the applicant commits to additional quality improvement and monitoring initiatives that it will implement including

enhanced service intensity relative to existing providers, ascribing to Chayim Aruchim, music and equine therapy, a virtual reality program, continuum palliative resources, a quality assurance performance improvement plan (QAPI), and continuing education and in-service training, (Attachment 1N – Pages 34-48).

- The applicant includes data on its affiliates most recent HQRP Process Measures as reported to CMS from Q1 2024 in Attachment 1N Pages 45-46.
- The applicant also provides data for its affiliate agencies related to CMS Quality of Patient Care – Percentage of Visits and Hospice Care Index (HCI) compared to the National Average. See Attachment 1N Page 46.

Note to Commission members: NIJH Accreditation includes annual training of staff members who interact with patients and patient's family members. NIJH does not evaluate clinical and non-clinical services nor conduct surveys of accredited hospices. The applicant states that its Affinity organization conduct their own internal and ongoing performance reviews to assure that Shalom Hospice is compliant with Jewish rituals, traditions and cultures.

Application Comments
Application Comments may be filed by the Department of Health, Department of Mental Health, and Substance Abuse Services, and the Department of Disability and Aging. The following department(s) filed comments with the Commission and are attached:

☐ Department of Health
☐ Department of Mental Health and Substance Abuse Services
☐ Department of Disability and Aging
☒ **No comments were filed**

Should the Agency vote to approve this project, the CON would expire in two years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:
There are no other Letters of Intent, outstanding applications, denied applications, or pending applications on file for this applicant.

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:
There are no other Letters of Intent, outstanding applications, denied applications or pending applications for other health care organizations in the service area proposing this type of service.

TPP (8/21/2024) revised

CRITERIA AND STANDARDS

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:

In total, the Applicant will employ 12.5 FTEs in Year 1; 9.3 of the 12.5 FTEs will be direct patient care positions. This includes 1 clinical director, 2 RN (ratio of 1:10) including part time RN floater, 1.8 aides (ratio of 1:8), 1 social worker (ratio of 1:25), 1 chaplain (to be an ordained rabbi, a ratio of 1:25), ½ an FTE for music therapy (a ratio of 1:50), 1 bereavement coordinator and 1 on-call nurse (ratio of 1:50). Shalom Hospice's staffing ratios exceed NHPCO Guidelines as well as the existing Service Area providers. In addition to the direct patient care position, Shalom Hospice will employ 3 non-patient care FTEs in Year 1. Shalom Hospice will have a medical director via contract services.

Shalom Hospice affiliates have significant operational success in its existing markets in recruiting and retaining qualified professionals. This is due in large part to its quality programming, service intensity in the hospice industry and the significant community linkages it establishes across the healthcare continuum and educational institutions. Evidence of successful integration into the Middle Tennessee healthcare community is demonstrated by the fact that Shalom Hospice in Middle Tennessee entered that community establishing linkages during its CON application process. After CON approval, it further developed those relationships and became licensed end of 2022 with a deficiency free survey. In February, it has become certified for Medicare, approximately 60 days after licensure and approximately 30 days after initiating services – with a deficiency free accreditation. It then became Medicaid certified as of May 1, 2023. The license and deficiency free documentation are included in **Attachment 5C.**

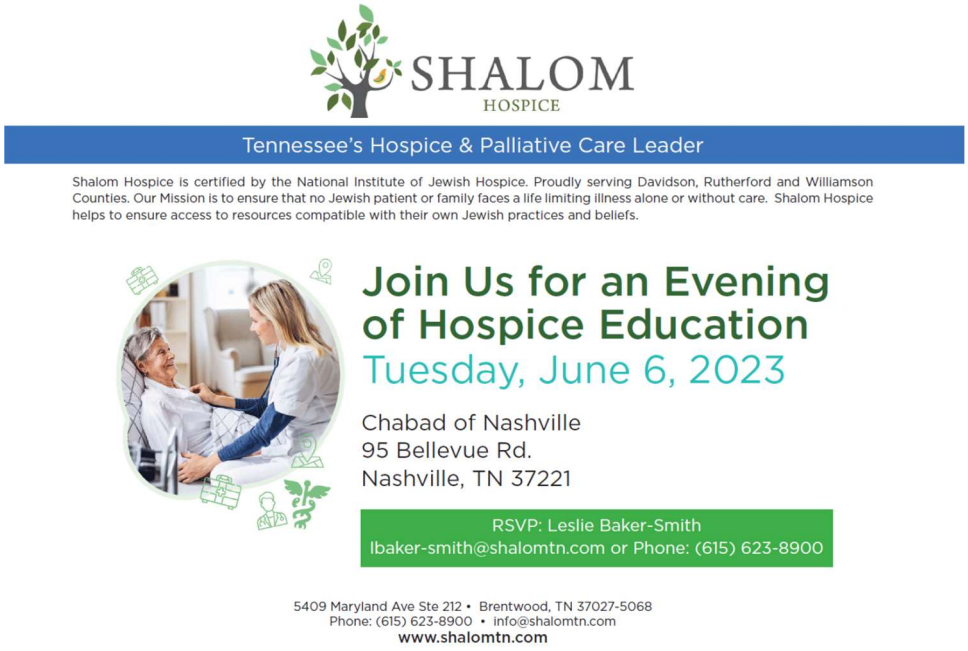
More importantly, it has demonstrated its ability to establish community linkages. Since becoming fully operational (February 2023), its admissions by referral source show a varied and comprehensive group of providers and constituents. Percentage by referral source for the 15-month period of February 2023 through April 2024 is presented in the following table:

Shalom Hospice of Middle Tennessee
Admissions by Referral Source
February 2023 through April 2024

Referral Source	Percent
Assisted Living Facility	20.4%
Hospital/Clinic	23.3%
Physician	10.7%
Skilled Nursing Facility/LTC	40.8%
Pharmacy	1.0%
Family Member	3.9%
Grand Total	**100.0%**

Source: Internal Shalom Hospice records.

Its efforts in expanding its community linkages which commenced during the CON application process are demonstrated with its quick entry into Middle Tennessee and its acceptance by a variety of providers. It initiated working with the Jewish organization as planned, retained an Orthodox Rabbi as its spiritual leader and is developing meaningful relationships with nursing homes, assisted living facilities and hospitals/physicians throughout the area. It is also engaging in the educational programs it designed for its constituents, with these programs being co-sponsored with Chabad of Nashville, Jewish Federation and four of the area nursing homes. These include Bethany Center for Rehab & Healing, Center for Rehab and Healing, Nashville Center for Rehab and Healing and Trevecca Center for Rehab and Healing. A sample advertisement for a co-sponsored event is shown below.



This ad was placed in The Observer, the only Jewish newspaper in Middle Tennessee and promoted by local organizations including Chabad of Nashville. Approximately 12 percent of its admissions are patients who identify as Jewish; this contrasts with 1 percent of the population being Jewish. Other denominations are selecting Shalom Hospice due to their spiritual programming, service intensity and specialty programs.

Like its development of relationships in Middle Tennessee, Shalom Hospice of Greater Knoxville has been successful in its short time of effort in its Service Area. Its pre-CON efforts initiated when a local Orthodox Jewish rabbi, Rabbi Yossi Wilhelm of Chabad Knoxville became aware of Shalom Hospice in Middle Tennessee. Rabbi Wilhelm believed there were similar barriers to access for his Jewish congregants and other Jewish residents of the Greater Knoxville area. Accordingly, the Rabbi requested Shalom Hospice consider developing a similar hospice with a Jewish emphasis in the Greater Knoxville area. Shalom Hospice undertook an analysis of the population and the stated barriers, confirmed there is an access issue for the Jewish population of Greater Knoxville and filed a CON application which was approved in August 2023. Shalom Hospice of Greater Knoxville had its initial license survey on December 13, 2023 which was deficiency free. It became NIJH accredited in January 2024, in advance of becoming Medicare certified. Its deficiency free Medicare certification survey did not occur until April 11, 2024. Its provider number is effective as of this date but it currently is awaiting receipt of this Medicare provider number. Once received, it will apply for Medicaid certification. The license and deficiency free documentation are included in **Attachment 5C.**

Despite this delay in receiving its provider number, it has initiated its community marketing efforts and collaboration with the existing Jewish organizations in the community. It is engaging in various educational events with Chabad of Knoxville, Knoxville Jewish Alliance and several area nursing homes and assisted living facilities. These facilities include Creekview Health & Rehab (Knox County), Beverly Park Place (Knox County), Island Home (Knox County), West Hills (Knox County), Jefferson City Health & Rehab (Jefferson County), Norris Post-Acute & Rehabilitation Center (Anderson County), Smoky Mountain Post-Acute & Rehabilitation Center (Sevier County) and The Waters of Clinton (Anderson County). Below is a recent promotion in the Knoxville Jewish Alliance newsletter.

Its dynamic efforts in the community are evident in that it has grown its average daily census to 25 since becoming Medicare certified in April. Its beginning patient admission rate in Greater Knoxville is 20 percent Jewish which far exceeds the proportion of Jewish population in the service area. One of its promotional publications has reached many Jewish families resulting in this significant support. This is shown below.

With respect to Southeast Tennessee, here again a local Rabbi was aware of Shalom Hospice in Middle Tennessee and the Knoxville area. Rabbi Shaul Perlstein initiated contact with Shalom Hospice, also voicing the access barriers for Jewish hospice services in his region of the state. In response, Shalom Hospice analyzed the area and confirmed there is a hospice access problem for the Jewish population of the region. This CON Application is in response to those requests and the supporting analysis.

While need is one consideration, consumer advantage is also a consideration in the CON criteria. With the licensure of Shalom Hospice, the Jewish population of the Greater Chattanooga area and Southeast Tennessee will have substantial consumer advantages and benefits since there is no like organization available to meet their end-of-life needs. Establishment of Shalom Hospice will introduce Availability and Choice to the area's Jewish population. It will also enhance access as it has been shared that oftentimes Jewish persons do not enroll in hospice due to not having options that consider the Jewish rituals, traditions and customs.

As part of its research and confirmation of the need for a Jewish hospice, Shalom Hospice of Southeast Tennessee has the pleasure of obtaining significant support from various religious organizations, healthcare providers and business leaders – each confirming the need for a hospice with a special emphasis on the Jewish population. This support specifically includes nursing homes providers throughout the area, area physicians, religious leaders and many community

representatives. Shalom Hospice will use these and other venues to recruit qualified, competent staff needed to provide safe and effective care to the hospice eligible Jewish and other population residing within this Service Area. The Applicant's staffing model demonstrates that the Applicant will far exceed general staffing guidelines and qualifications set forth by the National Hospice and Palliative Care Organization (NHPCO).

Shalom Hospice affiliates have significant operational success in its existing markets in recruiting and retaining qualified professionals. This is due in large part to its quality programming, service intensity in the hospice industry and the significant community linkages it establishes across the healthcare continuum and educational institutions. Another unique feature of Shalom Hospice affiliates is the travel program it has developed within its organization to enable nurses and others who are employed to volunteer to be temporarily or permanently placed in other service areas to meet the patients' needs of affiliate offices while accommodating employees' interests in relocation.

Shalom 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.

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 care system 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:

Shalom Hospice representatives have been in the Service Area for some time meeting with area nursing homes, assisted living facilities, physicians, and members of the Jewish community such as rabbis, Jewish Center, Jewish Cultural Center, Haddasah, Jewish Burial Society and other organizations supportive of a Jewish hospice agency. For an agency that is not yet licensed, Shalom Hospice has had great success in garnering support for its project reflective of the many letters of support from local clergy, Jewish organizations, nursing homes, assisted living facilities, community members and physicians/providers it has received.

This foundational support attests to the fact that the Applicant's community linkage plan has already begun. This extensive pre-licensure engagement with area organizations, referrals sources, admitting sources and spiritual leaders of the Jewish faith is a testament to the role Shalom Hospice will play within the Service Area. It also is the foundation of the Applicant's community linkage plan on a going forward basis.

With respect to letters, it should be noted these letters attest to the need for a Jewish hospice agency to serve Southeast Tennessee. In addition to these letters, which are described in greater detail

below, the Applicant plans on developing and securing additional relationships with area providers once it is approved and licensed.

The current state of relationships with influencers in the Service Area and support from these influencers are presented below.

Letters of Support for the Project

Both quantitative and qualitative need for Shalom Hospice's proposed project was relayed by 30 letters of support that identify the void that exists today of a Jewish hospice agency in the Service Area.[1] These letters specifically speak to the need for a faith-based end of life provider knowledgeable and experienced in providing personalized and culturally sensitive care within the framework of Jewish law and ritual, within Southeast Tennessee. The outpouring of support for the project is representative of Service Area physicians/providers, rabbis and Jewish congregations, assisted living facilities, nursing homes and others. Sponsors of letters of support are listed below, followed by letter excerpts submitted by the respective sponsors. Letters in their entirety are included behind **Attachment 1N-2** of this CON Application.

Physicians, Providers, Nursing Homes, Assisted Living Facilities and Home Health Support for the Project:

- Thomas Devlin, MD, PhD, FSVIN, CHI Memorial Neuroscience Institute, Director, Chattanooga Center for Neurologic Research LLC, Director, Neuroscience Innovation Foundation, Medical Director, CommonSpirit National Neuroscience Collaborative, Co-Director and Professor of Neurology, University of Tennessee Health Science Center
- Stephen V. Dreskin, MD, Tennessee Valley Pain Management
- Israel Franco, MD, Erlanger Urology
- Martin Simms, MD and Shelley Simms
- Karen E Hulley ACNP-BP, MSN, CCRN
- Ray Allen, Administrator, Soddy-Daisy Healthcare Center (Hamilton County)
- Lydia Sandberg, Director of Social Services, Life Care Center of Cleveland (Bradley County)
- Margaret Ferguson, Chaplain, Alexian Village Health and Rehabilitation Center (Hamilton County)
- Alicia Condra, Director of Nursing, Valley View Assisted Living (only ALF in Marion County)
- Bebe Kennedy, VP of Clinical Services, Morning Point Senior Living on behalf of its six area facilities:
    - Morning Pointe of Chattanooga
    - Morning Pointe of Collegedale at Greenbriar Cove
    - Morning Pointe of Hixson
    - Morning Pointe of Chattanooga at Shallowford
    - Morning Pointe of East Hamilton
    - The Lantern at Morning Pointe
- Ian Shives, Senior Executive Director, East Hamilton Morning Pointe (Hamilton County)
- Tess Greer, LPN, Wellness Director, Dominion Senior Living (Hamilton County)
- Sharon Scott, Resident Care Director, Regency House (Hamilton County)

[1] These letters are referenced herein; additional letters may have been sent directly to the Health Facilities Commission or will be submitted during the review period.

- Rachel Southerland, RN, Health and Wellness Director, Brookdale Mount Vernon (Bradley County)
- Bill Tobin, Client Care Manager, Preferred Care at Home
- Savannah Burkhart, General Manager, Home Instead

Jewish Congregations and Religious Affiliated Organizations/Persons Support for the Project:

- Rabbi Shaul Perlstein, Chabad of Chattanooga
- Rabbi Sam Rotenberg, Rabbi at B'nai Zion Congregation
- Charles “Chuck” J. Fleischmann, Member of Congress, Tennessee Third District
- Kevin M. Spiegel, FACHE, Former CEO Erlanger Health System and Assistant Professor of Medicine, UT, Current Assistant Professor Drexel College of Medicine, President & CEO Medical Expansion Partners, Chaplain, United States Chaplain Corps
- Sarah Aronson, 911 Ambulance Driver and Jewish Burial Society
- Thomas P. Balazs, Professor – University of Tennessee, Chattanooga and Advisor, Jew-TC
- Manuel V. Mendizabal, AWR Ambassador, General Conference of Seventh Day Adventist Church, Emeritus Ordained Minister, Southern Union Conference of Seventh Day Adventist Church
- Stonewall “Stoney” Ponders, Founder, Ponder Funeral Homes

Unaffiliated Community Supporters:

- Christine Duncan, Marion County resident
- Zachary Summit, Marion County resident

The above letter sponsors and the details of their letters of support are summarized below.

Physician/Provider Support for the Project:

Thomas Devlin, MD, PhD, FSVIN, CHI Memorial Neuroscience Institute, Director

> *“My name is Dr Thomas Devlin. I currently serve as the Chief of the Neuroscience Institute at CHI Memorial Hospital, Chattanooga. My specialty and clinical care skills are focused on the diagnosis and treatment of stroke patients. I serve as the lead physician on numerous international projects including the development of Artificial Intelligence (AI) technology to diagnose stroke very rapidly and at low cost, and in developing improved clot busting medication for stroke. My research team is also widely known for their current work developing new stem cell treatments and other pharmaceuticals that act as 'neuroprotectants' for stroke victims. I’m also partnered with CHI Memorial’s Center for Healthy Aging and professional staff to strengthen the Dementia-Alzheimer’s programs and offerings and establish new practices to close gaps in coverage that exist in the Chattanooga region. On a national level, I am the co-director of the CommonSpirit national Neuroscience Collaborative. CommonSpirit is currently the second largest health care system in America, and it is my job to facilitate communication and medical partnership between over 200 hospitals throughout the country.*

My patients are from Hamilton County and surrounding counties in Tennessee, including Marion, Sequatchie, Polk and Bradley Counties. As a neurologist with substantial numbers of both stroke and dementia patients, I am acutely aware of the need for certain specialized and high-quality end-of-life services for those with advanced stages of their conditions.

I was recently informed that Shalom Hospice is seeking regulatory approval to develop an in-home hospice program in southeast Tennessee. It operates similar programs in Middle Tennessee and the Greater Knoxville area. This hospice serves the special needs of the Jewish population. I am unaware of any existing hospice in our region which has a similar focus on the Jewish end of life traditions, rituals and practices. Given the richness of these traditions, and the spiritual and emotional support a Jewish faith-based hospice program will provide my Jewish patients, I am strongly in support of this initiative.

Coupled with its Jewish focus and programming, Shalom Hospice will also include some unique programs to meet the special needs of the Jewish population. Having learned about Shalom Hospice's virtual reality program, I find this very exciting as I know this will be of great benefit to patients. Virtual reality is an innovative way to bring a larger world to people who've found themselves limited to a room, or just a bed and Shalom Hospice is innovative for bringing this technology to its patients. Its virtual reality program is steeped in Jewish history and visitations to Jewish historical sites.

Shalom Hospice also has a service intense model of care that helps to avoid unwanted hospital re-admissions for patients. Their service intense hospice model enables the patient the opportunity to have a comfortable and peaceful passing right where they are, in their place of residence. This is of benefit to both Jews and non-Jews.

Please approve the Shalom Hospice CON application to provide end of life hospice services to my Jewish patients, the Jewish population throughout southeast Tennessee and others who will benefit from its spiritual programming. I would estimate that in any given month, we would identify between 1 and 5 patients or families who would benefit. I look forward to working with Shalom Hospice once it is licensed in our region."

Stephen V. Dreskin, MD, Tennessee Valley Pain Management

"I am a pain medicine specialist in Chattanooga, TN and have more than 13 years of experience in the field. I currently work with Tennessee Valley Pain Management and am well versed in controlling pain including those in terminal stages of their diseases. I am affiliated with Parkridge Medical Center.

Given my medical role, I see many patients in need of end of life care. As a physician who is also Jewish, I have the opportunity to observe end of life care and am also sensitive to meeting the special religious needs of this minority population.

I was recently informed that Shalom Hospice is seeking regulatory approval to develop an in-home hospice program in Southeast Tennessee to serve the special needs of the Jewish population. I am unaware of any existing hospice which has a similar focus on the end of life traditions, rituals and practices. Given the richness of these traditions, and the spiritual and emotional support a Jewish faith based hospice program will provide my Jewish patients, I am strongly in support of this initiative.

Coupled with its Jewish focus and programming, Shalom Hospice will also include some unique programs to meet the special needs of the Jewish population. Having learned about Shalom Hospice's virtual reality program, I find this very exciting and it will benefit these patients. Virtual reality is innovative way to bring a larger world to people who've found themselves limited to a room, or just a bed and Shalom Hospice is innovative for bringing this technology to its patients. Shalom Hospice also has a service intense model of care that helps to avoid unwanted hospital re- admissions for patients. Their service intense hospice model enables the patient the opportunity to have a comfortable and peaceful passing right where they are, in their place of residence.

Given the uniqueness of this program, I am confident it will be a community benefit for our patients and the public at large. I would anticipate with the size of our practice, that we would identify between 1 and 4 patients per month, depending on the month, who might consider this hospice program. Please approve the Shalom Hospice CON application to provide end of life hospice services to my Jewish patients and the Jewish population throughout the Greater Chattanooga area…."

Israel Franco, MD, Erlanger Urology

"…I am a Pediatric Urologist at Erlanger, with over 30 years of experience in the field and been listed repeatedly among Castle Connolly's top doctors. I received my medical degree from Albert Einstein College of Medicine and fellowship-trained at Lurie Children's Hospital in Chicago. I am an early innovator in Robotic and laparoscopic surgery, and developed and pioneered surgical techniques for undescended testis, hypospadias, prune belly syndrome, and renal and reconstructive surgery in pediatric urology. My work in neurological aspects of urinary incontinence for children with and without injuries to the nervous system has changed how these problems are managed today.

I am proud to be affiliated with Erlanger in southeast Tennessee. Our community is a vibrant one. As a practicing Jew, I am also fully engaged with Jewish traditions and rituals here in our region.

I am also aware that one of our Rabbi had contacted Shalom Hospice to determine Shalom Hospice's interest in meeting the end-of-life care needs of our Jewish population. The transition from life to death in Jewish tradition involves rituals and practices that provide support and comfort to the dying and anchors them in their faith. Unfortunately, this solace through ritual has not been available in our region because existing end of life organizations

dedicated to serving the sick and dying are not experienced in the many Jewish traditions surrounding the sick and dying. While those organizations provide meaningful services, they do not meet the end of life needs of our area's Jewish population.

Establishing a Jewish hospice program is critically important to meet the end of life needs of our community. Since this type of program is currently unavailable, establishing the program will not impact other providers but will in fact enhance hospice utilization amongst the overall population given the uniqueness of the program being proposed. Jewish patients and their families and caregivers' need for spiritual and cultural end of life care will only increase as our Jewish community ages.

Our Jewish elderly and terminally ill should be able to access Jewish traditions, rituals and nuances when receiving end of life care after a terminal diagnosis. Given the richness of these Jewish traditions, and the spiritual and emotional support a Jewish faith-based hospice program will provide our Jewish population, I am strongly in support of this initiative.

Given the underserved Jewish population, and the fact no similar program exists, I urge the HFC to approve the Shalom Hospice CON application to establish a Jewish hospice program. Please approve that CON application so that our people will have access to appropriate faith-based end of life care…"

Martin Simms, MD and Shelley Simms

"… I am a physician in private practice in Southeast Tennessee. My wife, Shelley, and I live in Chattanooga. We have been active members in the community since 1996 and believe there is an unmet need in the Jewish community for specialized faith based hospice services.

We were recently introduced to Shalom Hospice, which a local Rabbi solicited to establish a Jewish hospice in our region. Our understanding is they have done so in Middle Tennessee and the Greater Knoxville area. Expanding to our region is appropriate, and importantly addresses a currently unmet need.

Hospices currently serving our community are not optimally familiar with Jewish culture, rituals, and traditions; and consequently are not ideally suited to ease the spiritual anguish of the dying and their families. We support the establishment of a new hospice in the Chattanooga area, serving Hamilton, Marion, Sequatchie, Polk and Bradley counties. There are between 3,000 and 4,000 of the Jewish faith in the region, and it is important to have a specialized Jewish hospice program serving these residents.

Without a doubt, the Jewish community will benefit from a hospice provider that is experienced with Jewish culture and customs.

Thank you in advance for allowing us to voice our support for a much-needed Jewish hospice provider in Southeastern Tennessee."

Karen E Hulley ACNP-BP, MSN, CCRN

"I am a board certified nurse practitioner and have spent the majority of both my nursing and nurse practitioner career in critical care. By nature of this practice setting, and particularly during the COVID pandemic, I have spent a large amount of my job dealing with hospice and palliative care. Despite having such a large catchment area in Chattanooga at our tertiary care center, we do not have enough access to palliative and hospice care services. Patients distinctly feel more comfortable when they are able to spend their time at home and with their loved ones. Additional in-home hospice and palliative care services in this community would be very valuable to the Chattanooga community.

I was recently informed that Shalom Hospice is seeking regulatory approval to develop an in-home hospice program In Southeast Tennessee to serve the special needs of the Jewish population. I am unaware of any existing hospice which has a similar focus on the end of life traditions, rituals and practices. Given the richness of these traditions, and the spiritual and emotional support a Jewish faith based hospice program will provide my Jewish patients, I am strongly in support of this initiative.

Coupled with its Jewish focus and programming, Shalom Hospice will also include some unique programs to meet the special needs of the Jewish population. Having learned about Shalom Hospice's virtual reality program, I find this very exciting and it will benefit these patients. Virtual reality is innovative way to bring a larger world to people who've found themselves limited to a room, or just a bed and Shalom Hospice is innovative for bringing this technology to its patients. Shalom Hospice also has a service intense model of care that helps to avoid unwanted hospital re-admissions for patients. Their service intense hospice model enables the patient the opportunity to have a comfortable and peaceful passing right where they are, in their place of residence.

Given the uniqueness of this program, I am confident it will be a community benefit for our patients and the public at large. Given the acuity and large catchment area of our population, I am confident this will be a utilized service in our community. Please approve the Shalom Hospice CON application to provide end of life hospice services to my Jewish patients and the Jewish population throughout the Greater Chattanooga area…"

<u>Nursing Home, Assisted Living Facility and Home Health Support for the Project:</u>

Ray Allen, Administrator, Soddy-Daisy Healthcare Center

… We are a 134-bed licensed nursing home. We are located in Hamilton County at 701 Sequoyah Road, Soddy Daisy. Our residents are primarily Hamilton County residents and from surrounding communities. About half of our patients are TennCare with the remainder being Medicare and other payors.

By virtue of our location and our sponsorship, many of our patients have self-designated as being of the Jewish religion. As a nursing home operator, we provide support to these patients with their spiritual and emotional needs in accordance with our license. However, while we are licensed to provide skilled nursing services, we do not provide hospice end of life care.

The Jewish community has a rich history of visiting and comforting the sick and assisting them through death. The transition from life to death in Jewish tradition involves rituals and practices that provide support and comfort to the dying and anchors them in their faith. Unfortunately, this solace through ritual has not been available in our community because hospice organizations serving this area are not experienced in the many Jewish traditions surrounding the sick and dying.

However, Shalom Hospice that has an experienced, specialized team to service the Jewish community. In meeting with representatives from Shalom Hospice, it is my understanding that they are proposing a hospice in Southeast Tennessee to have a special emphasis on serving Jewish patients in end of life care. This is a service currently not available by existing providers and is a much-needed service. It would be a significant benefit to our community.

Shalom Hospice has demonstrated knowledge about Jewish traditions and rituals which enables them to relate to the spiritual needs of the Jewish community. Moreover, there are many patients at the end of life who cannot communicate well and most providers cannot penetrate the walls of dementia patients and those in a coma. Shalom Hospice not only connects patients to their religious roots but also through music therapy and virtual reality programs penetrates and touches their souls. It thus brings comfort to the most vulnerable of the Jewish population.

To that end, I have reviewed Shalom Hospice's proposed virtual reality program and their plan to have special Jewish focused virtual reality programs. The programs discussed with me that will benefit residents of Soddy Daisy Healthcare Center include historical footage of Jewish immigrants arriving in Ellis Island, Jewish shtetls in Poland, Russian, Ukraine and Galicia, Jewish ghettos in the Middle Ages, liberation of Auschwitz by American soldiers, modern Jewish life in America and modern Israel, among others. The investment in this type of technology to bring comfort and support to our Jewish patients in end of life care will be significant and meaningful. The bereaved families will also be able to participate in these activities.

As the operator of Soddy Daisy Healthcare Center, I strongly advocate for the approval of a hospice in Southeast Tennessee that has an emphasis on serving Jewish patients. Based on Shalom Hospice's planned programming, and our resident profile, I would expect our facility and its physicians will refer an average of at least 2 patients per month to Shalom Hospice.

For the benefit of our Jewish patients, our other patients who are interested in spiritual programming and the entire Jewish community in Southeast Tennessee, please approve the

Shalom Hospice CON application to meet the special end of life needs of the Jewish population of our community."

Lydia Sandberg, Director of Social Services, Life Care Center of Cleveland

"I am the Director of Social Services at Life Care Center of Cleveland. We are a 142-bed licensed nursing home. We are located in Bradley County at 3530 Keith Street, Northwest, Cleveland, TN. Our residents are primarily southeast Tennesseans, from Bradley and surrounding communities. More than half our patients are TennCare with the remainder being Medicare and other payors.

As part of our operations, some of our patients regularly benefit from hospice services. While we provide skilled nursing services, we are not licensed to provide hospice end of life care. Therefore we work collaboratively with these organizations.

We recently had the opportunity to meet with Shalom Hospice which is seeking to meet the needs of an underserved population in our area. We support this endeavor and encourage you to approve their CON application. Shalom Hospice programs of interest that will benefit our patients include its virtual reality, music therapy and service intensity.

Its virtual reality program allows patients and families to 'travel' and also includes a specific Jewish program for the Jewish population.

Shalom Hospice has a music therapy program that includes a board certified music therapist which will be an excellent benefit.

Its service intensity represents the level of patient touches; I find that excellent at 5 to 7 Home Health Aide visits per week, minimum of 2 RN visits per week and social worker and Rabbi (if the patient and family want a spiritual visit) at least weekly, which helps to keep families and loved ones well supported. Their rapid response to referrals will also be welcome 7 days per week. Based on our patients and knowledge of our community, I would anticipate referrals to Shalom Hospice will likely range between 2 and 3 per month.

Please approve Shalom Hospice to provide hospice services in southeast Tennessee…"

Margaret Ferguson, Chaplain, Alexian Village Health and Rehabilitation Center (Hamilton County)

"I want to take a moment to express my support for a proposed new hospice program to be established by Shalom Hospice of Southeast Tennessee. I am a Chaplain with Alexian Village Health and Rehabilitation Center, 622 Alexian Way, Signal Mountain, Hamilton County. We are a 114-bed skilled nursing facility serving a diverse population in southeast Tennessee. We [are] a part of the Alexian Village, a retirement village with independent living units, amenities and facilities for active and aging seniors.

I recently had the pleasure of meeting a representative of Shalom Hospice which is seeking CON approval to establish a specialized hospice program in our region to meet the needs of the underserved Jewish population as well as others throughout our community. As a Chaplain I was particularly interested in their spiritual programming, how that component of their hospice plan reaches the terminally ill in their final journey and how they work with the family members both during the illness and then after the passing of their loved ones.

The Shalom program is unique in its programming as there is not another such program in our region. Any Jewish patients we have would surely benefit from Shalom's programs, principals and protocols. In fact, other spiritually minded patients may also have an interest once Shalom receives its CON approval.

I look forward to the Health Facilities Commission approving Shalom Hospice so that we may work with Shalom Hospice when appropriate."

Alicia Condra, Director of Nursing, Valley View Assisted Living – the only ALF in Marion County

"I am the Director of Nursing for Valley View Assisted Living, the only assisted living facility in Marion County. We are located at 101 North Maple St, Whitwell, TN. We are an 80-bed facility serving Marion and surrounding counties.

It is my understanding that Shalom Hospice is proposing a new hospice program in our community. I have had the opportunity to discuss the Shalom Hospice proposal with its representatives and believe it will be an outstanding service provider addition in Marion County.

Shalom Hospice is seeking to meet some very specific underserved needs but will also admit any hospice appropriate patient that seeks its services, whether driven by its spiritual programming, service intensity or specialty programs. Each of these facets of its proposal are of interest to us as we believe our residents when appropriate for referral will benefit from rapid response, nearly daily patient touches, spiritual programming, music therapy and virtual reality. Given our resident profile, these referrals may number 1 to 3 per quarter.

I look forward to Valley View Assisted Living having the opportunity to work collaboratively with Shalom Hospice. To enable this, please approve Shalom Hospice's proposal to establish a new hospice program…"

Bebe Kennedy, VP of Clinical Services, Morning Point Senior Living on behalf of its six area facilities in the Service Area

"…I represent Morning Pointe Senior Living. We operate assisted living facilities throughout middle and east Tennessee. Our assisted living facilities are focused on meeting the needs of frail elderly in a nurturing, supportive and program rich environment.

We had the opportunity of being introduced to Shalom Hospice, which operates highly specialized hospices in Middle Tennessee and its most recent addition in the Knoxville area. We understand that Shalom Hospice is now applying to expand its offerings to our region, including the Chattanooga and Cleveland MSAs. Within this region, we operate the following assisted living facilities:

- *Morning Pointe of Chattanooga*
- *Morning Pointe of Collegedale at Greenbriar Cove*
- *Morning Pointe of Hixson*
- *Morning Pointe of Chattanooga at Shallowford*
- *Morning Pointe of East Hamilton*
- *The Lantern at Morning Pointe*

We are supportive of the HFC approving the Shalom Hospice application for several pertinent reasons which will benefit Morning Pointe residents and the community at large. Our reasons for this support are based on Shalom Hospice's referral response time, service intensity and spiritual programming.
These factors are highlighted below.

- *Respond to all referrals within one hour, initiate the assessment process within two hours, and expedite admission to the hospice subject to having a physician order in hand and the patient/family selecting the hospice option.*
- *5 to 7 Home Health Aide visits per week, provided this is acceptable to the IDT, patient and family.*
- *Minimum of 2 RN visits per week, provided this is acceptable to the IDT, patient and family.*
- *Provide a social worker and chaplain/Rabbi (if the patient and family want a spiritual visit) at least weekly, which helps to keep families and loved ones well supported.*
- *Increased visit frequency during the final weeks of life to provide support.*
- *Offering a comprehensive spiritual program for Jewish residents and other residents who are spiritually minded and interest in devotion in their final journey.*

With the above as Shalom Hospice's service commitment, we expect, based on our residents in our numerous facilities throughout this region, that each facility would likely have on average at least 1 referral per month.

We strongly urge you to approve Shalom Hospice to provide hospice services that will fill a void in available end of life care in our community.

Ian Shives, Senior Executive Director, East Hamilton Morning Pointe

"I am the Executive Director of Morning Pointe of East Hamilton, in Hamilton County Tennessee. We design each Morning Pointe Senior Living community to provide our residents with the personal care they need to feel supported while maintaining their independence. At

Morning Pointe we believe that seniors deserve the best care possible so that they can live a more joyful life including access to hospice care. We have both assisted living and memory care programs.

Recently, I met with Shalom Hospice and learned about their initiative to establish a hospice program in southeast Tennessee. They have a similar program in both Middle Tennessee and the Greater Knoxville area. Their goal is to meet the needs of the underserved religious minority but will serve all denominations. Shalom Hospice's approach is comprehensive, and its tailored programs will be valuable to our community.

Shalom's service intensity is impressive. I learned that they have a quick response time to all new referrals. As the Executive Director, I know that will only enhance the accessibility to hospice care for all of my residents. Their service intensity of boots at the bedside with almost daily patient touches is notable and a program differentiator. 5 to 7 aide visits per week, RN twice weekly and weekly social worker and chaplain/Rabbi will benefit each of our residents who requires hospice care. I was also impressed with their specialty programs of music therapy and virtual reality. These are unique programs they will offer to all patients at no cost regardless of funding. Given our resident profile and community, I would expect referrals to average 1 per month.

Morning Pointe of East Hamilton looks forward to working with Shalom Hospice and strongly supports their mission and application to establish a hospice program in our community…"

Tess Greer, LPN, Wellness Director, Dominion Senior Living

"I am the Wellness Director for Dominion Senior Living of Hixson, located at 2143 Northpoint Boulevard, Chattanooga, Hamilton County. Our assisted living facility is licensed for 67 beds, 32 of which are specialized for residents with Alzheimer's and other forms of dementia.

I recently learned about Shalom Hospice that has an experienced, specialized team to service the Jewish community. They began providing these services in Middle Tennessee early last year and most recently in the Knoxville area. It is my understanding that they are proposing a hospice in the Greater Chattanooga area to have a special emphasis on serving Jewish patients in end of life care. This is a service currently not available by existing providers and is a much-needed service. It would be a significant benefit to our community since Hamilton and the surrounding counties have most of the Jewish population in our region.

Shalom Hospice has demonstrated knowledge about Jewish traditions and rituals which enables them to relate to the spiritual needs of the Jewish community. Moreover, there are many residents at the end of life who cannot communicate well and most providers cannot penetrate the walls of those residents with dementia. Shalom Hospice not only connects residents to their religious roots but also through music therapy and virtual reality programs which penetrate and touch their souls. It thus brings comfort to the most vulnerable of the

Jewish population. I am in favor of the HFC approving Shalom Hospice for the following reasons:

- *Supporting the Jewish population in my facility and in our region, including the terminally ill and their families;*
- *Providing music therapy by a board certified music therapist with frequent visits, with the program including historical Jewish singing, prayers and other ties to Jewish heritage;*
- *Responding to referred patients within two hours of receiving the referral, seven days per week.*
- *Interacting with its patients almost daily each week provides another set of clinical and watchful eyes for our residents, including those with dementia. Its care teams see patients 5 to 7 days per week by aides, minimum two visits per week by RN, and weekly visits by social workers and chaplains/rabbis.*

Each of these programmatic features are of interest to me and our facility; they will enhance access to hospice services for my residents.

As the Wellness Director, I strongly advocate for the approval of Shalom Hospice with its emphasis on serving Jewish patients and providing a service intensity and specialty programming that will benefit all patients.

For the benefit of our residents and the overall community, please approve the Shalom Hospice CON application to meet the special end of life needs."

Sharon Scott, Resident Care Director, Regency House

"My name is Sharon Scott and I am the Resident Care Director for our 54-bed Regency House Assisted Living Facility located at 2062 Hamill Road, Hixson, Hamilton County. I have had the opportunity to learn about Shalom Hospice and its specialized programming. Their specialized services of interest to me on behalf of my residents include the following:

- *Its Service Intensity of interacting with its patients almost daily each week provides another set of clinical and watchful eyes for our residents. My understanding is that Shalom Hospice's care teams see patients 5 to 7 days per week by aides, minimum two visits per week by RN, and weekly visits by social workers and chaplains/rabbis.*
- *Shalom Hospice also responds to referred patients in crisis within two hours of receiving the referral. All other patients are seen within the day. This will enhance access to hospice services for my residents.*

This level of service intensity is not available in our region; we therefore embrace it as we know it will benefit our residents and their families.

Additionally, Shalom Hospice is spiritually oriented given its origin and focus on incorporating religious beliefs into its care program. I believe some of our residents will also embrace this important facet of Shalom Hospice's programming. When approved and licensed, we intend on working with Shalom Hospice to introduce its specialized programming at our facility.

Please approve their CON Application for Southeast Tennessee…."

Rachel Southerland, RN, Health and Wellness Director, Brookdale Mount Vernon (Bradley County)

"I am the Health and Wellness Director of Brookdale Mount Vernon in Cleveland Tennessee. We have had the opportunity of being introduced to Shalom Hospice, which operates highly specialized hospices in Middle Tennessee and its most recent addition in the Knoxville area. We understand that Shalom Hospice is now applying to expand its offerings to our region, including the Chattanooga and Cleveland MSAs. We are supportive of the HFC approving the Shalom Hospice application for several pertinent reasons which will benefit our Brookdale community.

Our reasons to support Shalom Hospice's CON application are as follows:

- *Its service intensity which we understand includes the following patient touches on an ongoing basis:*
  - *5 to 7 Home Health Aide visits per week, provided this is acceptable to the IDT, patient and family.*
  - *Minimum of 2 RN visits per week, provided this is acceptable to the IDT, patient and family.*
  - *Provide a social worker and chaplain/Rabbi (if the patient and family want a spiritual visit) at least weekly, which helps to keep families and loved ones well supported.*
  - *Increased visit frequency during the final weeks of life to provide support.*
  - *Respond to all referrals within one hour, initiate the assessment process within two hours, and expedite admission to the hospice subject to having a physician order in hand and the patient/family selecting the hospice option.*
- *Virtual reality: This is a highly unique program for our area and will enable residents to benefit from travel when they are physically no longer able to do so. This will also benefit the patients' families.*
- *Music therapy: This will not only benefit the hospice patients but also other residents of our facility who are able to listen to this music programs.*

With Shalom Hospice's service commitment as detailed above, we expect to refer at least one patient per month to Shalom Hospice. We strongly urge you to approve Shalom Hospice to provide hospice services that will fill a void in available end of life care in our community..."

Bill Tobin, Client Care Manager, Preferred Care at Home

"My name is Bill Tobin and I am the Client Care Manager for Preferred Care at Home of Chattanooga–a licensed provider of non-medical, personal care services based in Hamilton County. As one of the area's leading home care agencies, we owe our 15 year track record of success to the special attention we pay to our clients' individualized needs for personal happiness and spiritual fulfillment above all else.

I want to express my support for a proposed new hospice program with whom we share these values: Shalom Hospice of Southeast Tennessee. This hospice is seeking Certificate of Need approval to establish a specialized hospice program in our region to meet the needs of the underserved Jewish population as well as others with unique spiritual needs.

The comprehensive, broad spectrum of essential end-of-life services that Shalom Hospice has planned for the older adult population of Southeast Tennessee would truly be unique in our market. Our agency is particularly interested in their spiritual programming, how that component of their hospice plan reaches the terminally ill in their final journey, and how their team will work with family members, both during the illness and after the passing of their loved ones.

Given the geographic footprint of the market we cover and the base of clients and families we serve, I anticipate that we would enjoy a mutual collaboration with Shalom Hospice as referring partners once they are granted licensure. I look forward to the Health Facilities Commission approving Shalom Hospice so that we may work with Shalom Hospice when that time comes.''

Savannah Burkhart, General Manager, Home Instead

"… Our home care services can help aging adults stay engaged in everyday life with tailor-made support by professional caregivers to stay safe and well at home.

I want to express my support for a proposed new hospice program to be established by Shalom Hospice of Southeast Tennessee. This hospice is seeking CON approval to establish a specialized hospice program in our region to meet the needs of the underserved Jewish population as well as others who are spiritual and reside throughout this region.

Shalom Hospice's service intensity is unique and not currently available in our region. It will be of particular interest to our home care clients and their families. In terms of service intensity, we understand the Shalom Hospice program includes the following patient touches on an ongoing basis:

- *Respond to all referrals within one hour, initiate the assessment process within two hours, and expedite admission to the hospice subject to having a physician order in hand and the patient/family selecting the hospice option.*
- *5 to 7 Home Health Aide visits per week, provided this is acceptable to the IDT, patient and family.*
- *Minimum of 2 RN visits per week, provided this is acceptable to the IDT, patient and family. Provide a social worker and chaplain/Rabbi (if the patient and family want a spiritual visit) at least weekly, which helps to keep families and loved ones well supported.*
- *Increased visit frequency during the final weeks of life to provide support.*
- *Offering a comprehensive spiritual program for Jewish residents and other residents who are spiritually minded and interest in devotion in their final journey.*

Given our home care footprint and patients we are referred and/or admit, I would expect there to be mutual collaboration with Shalom Hospice including referral of appropriate patients on a regular basis…."

Jewish Congregations and Religious Affiliated Organizations/Persons Support for the Project:

Rabbi Shaul Perlstein, Chabad of Chattanooga

"My name is Rabbi Shaul Perlstein and I am honored to be the Rabbi of Chabad of Chattanooga. I have been the Rabbi of Chabad of Chattanooga and the Jewish community in the Greater Chattanooga area since 2009, approximately 15 years. The origins of today's Chabad-Lubavitch organization can be traced to the early 1940s, when the sixth Lubavitcher Rebbe, Rabbi Yosef Yitzchak Schneersohn of righteous memory (1880–1950), appointed his son-in-law and later successor, Rabbi Menachem Mendel, to head the newly founded educational and social service arms of the movement. Motivated by his profound love for every Jew and spurred by his boundless optimism and self-sacrifice, the Rebbe set into motion a dazzling array of programs, services and institutions to serve every Jew.

Today over 5,000 full-time emissary families (2,000 in the United States) apply 250-year-old principles and philosophy to direct more than 3,500 institutions (and a workforce that numbers in the tens of thousands) dedicated to the welfare of the Jewish people worldwide.

Chabad of Chattanooga is located at 950 Vine Street, Chattanooga, Tennessee, serving Hamilton and surrounding counties, including Sequatchie, Marion, Bradley and Polk. Residing throughout this area, I estimate there are between 3,000 and 4,000 Jewish persons representing all stream of the Jewish religion – Orthodox, Conservative, Reform and Unaffiliated. Throughout my time in southeast Tennessee, I have ministered to congregants and the community in each of the noted counties throughout their lives. My services include officiating at funerals, being with families during the last moments of loved ones, transmitting bodies to other locations for burial, among other near ed or end of life services.

I am the Director of the Jewish Burial Society of Chattanooga; it is known as Chevra Kadisha, which I describe below. I am also a Credentialed Clergy of Greater Chattanooga (CCGC). In that role, I visit all hospitals in Hamilton County. Additionally, as CCGC, I visit nursing homes and assisted living facilities, including (but not limited to) Alexian, Life Care Centers, Ashwood and many others. In Bradley County I visit the Tennova Hospital and Avail Senior Living. These facility visits are in addition to the countless homes I visit from throughout our region, both in state and out of state, and particularly in the five counties in which Shalom Hospice is seeking approval to meet the end of life needs of the Jewish population to whom I minister.

I have some unique perspectives relative to end of life care for Jewish patients. First, during my tenure as Rabbi, I have been called many times to hospitals, nursing homes and private residences to attend to the needs of actively dying Jewish patients. Some of these Jewish community members are on hospice, while others are not. Those on hospice are not provided with services consistent with Jewish laws, rituals and culture. I have witnessed firsthand the passing of a Jewish person, and the hospice unable to meet the dying person and family's needs. The lack of culture and understanding can be upsetting and unsettling to Jewish patients and families.

Second, while called upon by families to attend to end of life care, despite being in this region for 15 years, I have never been called by any of the hospices in this region to provide spiritual services to any of their patients. This further confirms my opinion that the Jewish person is unserved, or underserved, relative to the provision of end of life hospice care.

My third perspective of the need for Jewish focused end of life programming is that I am the Director of the local Chevra Kadisha. Chevra Kadisha is a sacred burial society which cares for the Jewish deceased and prepares them for burial in a manner that is consistent with Jewish law. In that capacity, I have come to see firsthand the incredible need for an organization like Shalom Hospice that provides for the Jewish end of life needs.

From a geographic perspective, I am called upon to minister with Jewish persons throughout southeast Tennessee, in addition to Hamilton County. In Hamilton County, I am very active with the hospitals, nursing homes and assisted living facilities. Similarly, in Bradley County I frequent Tennova Hospital and senior living facilities. Throughout this region, there are more than 3,000 persons of the Jewish faith and I respond to all situations including those involving the passing of one of our community members, regardless of their affiliation.

As the Rabbi and through Chevra Kadisha, I am in a position to evaluate the end-of-life needs of Jewish patients and measure the quality of end-of-life services. I am acutely aware of cultural sensitivities and nuances that make for comfortable and peaceful passing. I am intimately familiar with Jewish customs, in general, and end-of-life issues in particular. Therefore, I can state with full conviction that existing hospice providers are not culturally sensitive to the needs of Jewish patients and families. They have been lacking in the spiritual and religious needs of the Jewish community.

Shalom Hospice understands the unique requirements of the Jewish population relative to end of life rituals, traditions and customs. For Jewish patients and their families, Shalom Hospice will provide personalized care within the framework of Jewish law and ritual. For example, a central feature of the Jewish ritual for the dying is recitation of Vidui, the Confessional Prayer Before Death. Shalom Hospice, in a very sensitive manner, encourages saying Vidui to give the dying person the chance to confess sins and ask for forgiveness. Shalom Hospice assists the dying and the family by taking religious and spiritual needs into account.

Based on my 15 years of experience as a member of the Jewish clergy in the Chattanooga area, I would expect there to be substantial referrals of Jewish community members and friends to Shalom Hospice, including through our organizations, Chabad of Chattanooga and Chevra Kadisha.

Given the absence of end of life hospice services to meet the needs of dying Jewish patients in southeast Tennessee, I strongly urge the Tennessee Health Facilities Commission to approve the certificate of need application by Shalom Hospice to establish a hospice in this region of the state. We are grateful for your consideration and are available to respond to any questions you may have. Thank you."

Rabbi Sam Rotenberg, Rabbi at B'nai Zion Congregation

"… I am the Senior Rabbi at B'nai Zion Congregation. We are a conservative temple located at 923 McCallie Avenue, Chattanooga. Established in 1880s as Brethren from B'nai Chein, an orthodox congregation. The congregation's name was changed to B'nai Zion in 1924. In 1961, it changed its affiliation from orthodox to conservative, which it remains today. We have a robust community with a mission to provide the Greater Chattanooga a community dedicated to the celebration of conservative Jewish life inspired by Torah, education and tikkun olam.

As the Senior Rabbi of our congregation, I am involved in many facets of my congregants' lives. One of the most stressful tasks is dealing with the terminally ill, and hospice is no different. It is my experience that the hospices currently serving our congregants are not familiar with Jewish cultures, rituals, and traditions. The returning of one's soul to God at the end of its journey in this world is the most profound moment in a person's life. It is said that there are no atheists in a foxhole.

Similarly, when faced with death the human soul craves the solace found in religion. At that moment of truth as the soul approaches eternal life in heaven, religion becomes a source of comfort and peace. Most end-of-life providers are not familiar with Jewish rituals and customs and consequently are unable to ease the spiritual anguish of the dying and their families.

I understand that Shalom Hospice is seeking approval to establish a new hospice in southeast Tennessee to serve Hamilton, Marion, Sequatchie, Polk and Bradley Counties. With between

2,000 and 3,000 Jews in this area, it is particularly important to have a specialized Jewish hospice program available to meet their end of life needs.

I've reviewed information provided regarding Shalom Hospice and their vision and mission to serve our Jewish community. I am impressed by their knowledge of the Jewish culture and what they plan to implement. Whether to recite Vidui and Shema or gather a quorum for saying Kaddish, Shalom Hospice assured me that they will be there and will provide services in a most respectful and appropriate manner.

As part of Shalom Hospice's programming, I also look forward to them hosting educational programs for our constituents, and also utilizing their team members to provide bereavement support to our families regardless of whether their family members were Shalom Hospice patients. This will be a great service for the entire community.

Without a doubt, the Jewish community and others will benefit from a hospice provider that is experienced with the Jewish cultures and customs. Please approve Shalom Hospice's application for the Certificate of Need. … Since I took over at B'nai Zion Congregation, I have felt supported in helping our congregation navigate the complicated emotions and technicalities after someone dies. Before they pass, I have heard many complaints about how our local hospice care does not treat them in a way that honors their Jewish identity. Not to disparage the good work they do - they just do not fully understand how to frame dying in a Jewish way. I look forward to being able to offer Shalom Hospice as an option so our congregants feel supported not only after they pass, but also in the days and weeks preceding their departure from this earth."

Charles "Chuck" J. Fleischmann, Member of Congress, Tennessee Third District

"I represent Tennessee's Third Congressional District which includes 10 counties: Anderson, Bradley, Campbell, Hamilton, McMinn, Monroe, Morgan, Polk, Roane, and Scott.

I am aware that one of our local Rabbis contacted Shalom Hospice to determine Shalom Hospice's interest in meeting the end-of-life care needs of the Jewish population in Southeast Tennessee. The Rabbi was aware that Shalom Hospice had established similar hospices in Middle Tennessee and most recently in the Greater Knoxville area. I wholeheartedly support this effort to bring these services to this area.

The transition from life to death in Jewish tradition involves rituals and practices that provide support and comfort to the dying and anchors them in their faith. Unfortunately, this solace through ritual has not been available because existing end-of-life organizations dedicated to serving the sick and dying are not experienced in the many Jewish traditions related to late-stage care. While those organizations provide meaningful services, they do not meet the end-of-life needs of our local Jewish population.

Establishing a Jewish hospice program is critically important to meet the end-of-life needs of the Jewish population. Since this type of program is currently unavailable, establishing the program will not impact other providers but will in fact enhance hospice utilization amongst the overall population given the uniqueness of the program being proposed. Jewish patients and their families and caregivers' need for spiritual and cultural end of life care will only increase as our Jewish community ages.

Our Jewish elderly and terminally ill should be able to access Jewish traditions, rituals and nuances when receiving end of life care after a terminal diagnosis. Given the richness of these Jewish traditions, and the spiritual and emotional support a Jewish faith-based hospice program will provide our Jewish population, I am strongly in support of this initiative.

Given the underserved Jewish population, and the fact no similar program exists, I urge the HFC to give all due consideration the Shalom Hospice CON application to establish a Jewish hospice program here in Southeast Tennessee and enable more members of our community to have access to appropriate faith-based end-of-life care…"

Kevin M. Spiegel, FACHE, Former CEO Erlanger Health System and Assistant Professor of Medicine, UT, Current Assistant Professor Drexel College of Medicine, President & CEO Medical Expansion Partners, Chaplain, United States Chaplain Corps

"I am pleased to provide my total support for the Shalom Hospice to establish a new hospice in southeast Tennessee. By way of background, my name is Kevin Spiegel. I previously had the pleasure to serve as the Chief Executive Officer for Erlanger Health System and Assistant Professor of Medicine at the University of Tennessee.

The transition from life to death in Jewish tradition involves rituals and practices that provide support and comfort to the dying and anchors them in their faith. Existing hospices in southeast Tennessee are not experienced in the many Jewish traditions surrounding the sick and dying. While the existing hospices provide meaningful services for some population groups, they do not meet the end of life needs of this area's Jewish population. Those who are diagnosed as terminally ill – and Jewish – are underserved at their most vulnerable point in their lives, as they near the end with terminal diagnoses.

Having a Jewish hospice to meet these specialized end of life needs of the Tennessee's Jewish population is of utmost importance to guide these people through their transition from life to death. I understand the HFC previously approved similar hospices to serve Middle Tennessee and the Greater Knoxville area.

It is now important the HFC does the same for the Greater Chattanooga area and allow Shalom Hospice to establish a Jewish hospice to meet the end of life needs of our Jewish population.

Jewish patients and their families and caregivers need for spiritual and cultural end of life care will only increase as our Jewish community ages. Our Jewish community will benefit from

having access to a Jewish hospice program; such a program does not exist so many of these persons have unmet needs in end of life. Shalom Hospice has a full understanding of the unique requirements of the Jewish population and will implement its specific hospice program to meet the special needs of Jewish people in end of life care.

Shalom Hospice will provide personalized care within the framework of Jewish law and ritual. Shalom Hospice will assist the dying and the family by taking religious and spiritual needs into account. Having a Jewish hospice to not only provide the hospice care and innovative related programming, but also associated bereavement services is important to our community and we would appreciate all your assistance to this end.

I am in full support of Shalom Hospice's application for the certificate of need to develop a Jewish hospice program in southeast Tennessee and provide a necessary, currently unavailable, service for the Jewish community.

Sarah Aronson, 911 Ambulance Driver and Jewish Burial Society

"My name is Sarah Aronson. I have the pleasure of serving the community of Hamilton County as a paramedic on a 911-only ambulance service and also serve on our area's Jewish Burial Society, known as Chevra Kadisha. I have two unique perspectives relative to end of life care for Jewish patients. First, as a paramedic, I have seen firsthand actively dying Jewish patients that were not served properly by our local hospices. This is in part due to the fact that most hospice services are not based around jewish faith and therefore do not know or understand our customs regarding end of life care.

My second view of the need for Jewish focused end of life programming is that I serve on our area's Chevra Kadisha. Chevra Kadisha is a sacred burial society which cares for the Jewish deceased and prepares them for burial in a manner that is consistent with Jewish law. In that capacity, I have come to see firsthand the incredible need for an organization like Shalom Hospice that provides for the Jewish end of life needs. There are very few of us here in Hamilton County who fully understand and have the capabilities of handling jewish burial preparations.

Given these two complementary roles, I am in a position to evaluate the end-of-life needs of Jewish patients and measure the quality of end-of-life services. I am acutely aware of cultural sensitivities and nuances that make for comfortable and peaceful passing within the jewish faith. I am intimately familiar with Jewish customs, in general, and end-of-life issues in particular. Therefore, I can readily state that existing hospice providers are not culturally sensitive to the needs of Jewish patients and families. They have been lacking in the spiritual and religious needs of the Jewish community.

Shalom Hospice understands the unique requirements of the Jewish population relative to end of life rituals, traditions and customs. For Jewish patients and their families, Shalom Hospice will provide personalized care within the framework of Jewish law and ritual. For example, a

central feature of the Jewish ritual for the dying is recitation of Vidui, the Confessional Prayer before Death. Shalom Hospice, in a very sensitive manner, encourages saying Vidui to give the dying person the chance to confess sins and ask for forgiveness. Shalom Hospice assists the dying and the family by taking religious and spiritual needs into account.

Based on my experiences, I would expect there to be substantial referrals of Jewish community members and friends to Shalom Hospice through the various Jewish organizations in our region. Given the absence of end of life (hospice) services to meet the needs of dying Jewish patients, I strongly urge the HFC to approve the certificate of need application by Shalom Hospice to establish a jewish hospice in Southeast Tennessee. We are grateful for your consideration and are available to respond to any questions you may have. Thank you."

Thomas P. Balazs, Professor – University of Tennessee, Chattanooga and Advisor, Jew-TC

"Please accept my letter of support for Shalom Hospice's ongoing effort to obtain approval to offer its hospice care services in Southeast Tennessee. I'm a Professor of English at the University of Tennessee at Chattanooga (UTC) and serve as an advisor for Jew–TC, a Jewish organization for students at UTC.

I was interested to learn that Shalom Hospice intends to offer its accredited program here in the Chattanooga area. Thousands of years of Jewish tradition provide guidelines helping people manage the end-of-life period of crisis—prayers, rituals, and religious symbols that most Jews observe at least in part. It's important that hospices educate and train their employees about these practices and customs when serving Jewish end-of-life patients. That's why it's vital for our region of Tennessee to offer Jewish hospice services.

I understand that volunteerism is also an important part of the hospice Medicare program. Our vibrant student community could share their diverse talents with families, whether through music, writing, or other forms of service. Furthermore, the potential for internships in various fields, such as nursing, chaplaincy, social work, and business administration, would provide invaluable opportunities for our students.

All told, our Jewish community would benefit immensely from a hospice provider experienced with Jewish cultures and customs. I'm deeply grateful for the opportunity to voice UTC and Jew-TC support for a much-needed Jewish hospice provider to come to our area…"

Manuel V. Mendizabal, AWR Ambassador, General Conference of Seventh Day Adventist Church, Emeritus Ordained Minister, Southern Union Conference of Seventh Day Adventist Church

"... I am an emeritus ordained minister in good standing with the Southern Day Adventist Church (Southern Union Conference) and World Radio Ambassador. I transitioned from Pastor to Pastor Emeritus when I decided to pursue my Jewish heritage and now observe Judaism.

Given my unique history, I have a front row seat to various religious denominations and recognize the importance of abiding by rituals and traditions, regardless of what faith someone ascribes to.

I had the great fortune of meeting a representative of Shalom Hospice which is seeking CON approval to establish a specialized hospice program in our region to meet the needs of the underserved Jewish population as well as others throughout our community. Given my position, I was particularly interested in their spiritual programming, how that component of their hospice plan reaches the terminally ill in their final journey and how they work with the family members both during the illness and then after the passing of their loved ones.

Towards the end of life, we find many in our community turning to their traditions. The Shalom program is unique in its programming as there is not another such program in our region. Having a hospice that is sensitive to and knowledgeable of Jewish practice and tradition could be immensely helpful at this time of life. Any Jewish patients and their families would surely benefit from Shalom's programs, principals and protocols. Especially in this time of escalated antisemitism, it is particularly important to have an organization that understands Jewish traditions, rituals and culture. Additionally, other spiritually minded patients may also have an interest once Shalom receives its CON approval.

I urge and encourage you to approve the Shalom Hospice application to establish a hospice in the Greater Chattanooga area to serve Jewish persons and their families throughout southeast Tennessee. …"

Stonewall "Stoney" Ponders, Founder, Ponders Funeral Homes

"My name is Stonewall Ponders. I am the owner of Ponders Funeral Homes, the primary funeral source for the Jewish residents of southeast Tennessee. Ponders Funeral Homes was established in northwest Georgia in 1992. As a graduate of Gupton-Jones College of Funeral Service and member of the Pi Sigma Eta National Morticians Fraternity, I realized a lifelong dream of owning my own funeral home. This dream became reality when we began serving Dalton area families in 1992.

To serve families in Tennessee, the Brainerd (Hamilton County) location of Ponders Funeral Home opened in 2018. This location features a chapel capable of accommodating 400 guests, as well as several parlors that are available for viewings and visitations. Located at 4203 Brainerd Road, Ponders Funeral Home is proud to be able to serve families in and around Chattanooga, TN.

As a family owned and operated business, Ponders Funeral Home strives to assist families in creating a memorable and sophisticated service to celebrate the life of your loved one. Offering a wide variety of options for personalization and willing to work within a family's financial needs, you can feel confident in knowing that the memory of your loved one will be handled with honor and respect.

As the founder of Ponders, I understand and am acutely aware of cultural sensitivities and nuances that make for comfortable and peaceful passing. I am somewhat familiar with Jewish customs, both preceding death and after passing based on my 30+ years in the business. The area's Jewish population who become terminally ill should be afforded the opportunity to have in-home end of life hospice services consistent with their religious beliefs. Assuredly, based on my perspective, I can state that the existing hospice providers have not been culturally in tune with the needs of Jewish patients and families and been lacking in the spiritual and religious needs of the Jewish community.

Furthermore, I regularly counsel the bereaved as a funeral director. Having an available Jewish hospice program to provide bereavement services for 13 months from passing, in accordance with Medicare requirements, would be an outstanding resource for me to introduce to the many constituents I encounter from my position with Ponder Funeral Homes.

Shalom Hospice has focused on establishing programs and services which are aligned with the cultural, tradition, and rituals required in meeting the end of life needs of the Jewish population. The organization has demonstrated its caring staff and innovative programs guide the patients and their families through the age old rituals offering comfort and support and affirming Jewish identity and connection. The Southeast Tennessee community would be well served if Shalom Hospice is awarded a Certificate of Need to provide end of life care to Jewish patients, including long term bereavement services for the survivors.

In my capacity, I strongly advocate for the approval of Shalom Hospice. Shalom Hospice would fill a great void and dire need for the Jewish community. Please approve Shalom Hospice's application for the Certificate of Need to develop a hospice program in our region…"

<u>*Unaffiliated Community Supporters*</u>

Christine Duncan, Marion County resident

"My name is Christine Duncan. I am a retired teacher and have been a resident of Marion County, Tennessee since 1997. Given my age and experience, I am quite familiar with healthcare resources throughout this area.

I have had the pleasure of learning about Shalom Hospice, a proposed faith-based hospice program seeking State approval to license and operate a proposed hospice. It has identified persons of the Jewish faith in this region as underserved and wants to bring specific faith based programming and spiritual services to meet the needs of this population. It will also offer a non-denominational aspect of its overall and spiritual programming as it will admit all patients, regardless of religion.

Shalom Hospice will be different than other providers with its specialized programming and services. It plans to have music therapy, virtual reality and equine therapy. It will also have a

service intensity different than other providers which includes 5 to 7 aid visits per week, weekly visits by social worker and chaplain and twice weekly by nurses. This kind of patient and family engagement will benefit consumers in this region.

As a consumer, I recommend you approve the Shalom Hospice CON application to provide our community with these additional resources. Its program will benefit the consumers of Marion and other counties in our region..."

Zachary Summit, Marion County resident

"My name is Zachary Summit. I have been a resident of Marion County since 2007. As a resident of the Greater Chattanooga area, I have an understanding of available healthcare services in our area.

I recently learned about Shalom Hospice, a proposed faith-based hospice program seeking State approval to license and operate a proposed hospice. It has identified religious minorities (persons of the Jewish faith) as underserved and wants to bring specific faith based programming and spiritual services to meet the needs of this population. It will also offer a non-denominational aspect of its overall and spiritual programming as it will admit all patients, regardless of religion.

My understanding is that Shalom Hospice will differentiate its services from other providers by offering almost daily patient visits, music therapy, virtual reality, and equine therapy.

As a consumer in this area, I recommend you approve the Shalom Hospice CON application to provide our community with these additional resources. Its program will benefit the consumers of Marion and other counties in our region…."

In addition to the above support for Shalom Hospice, upon both approval and licensure, Shalom Hospice will network with existing healthcare providers and referral sources throughout the Service Area. It will educate the existing healthcare providers and referral sources about the unique attributes of Shalom Hospice and the terminally ill population it will serve. Shalom Hospice will establish formal referral relationships with area physicians who manage the care of hospice appropriate patients, local nursing homes, hospital discharge planners and assisted living facilities. Shalom Hospice will regularly attend community health events and provide marketing materials and brochures detailing the unique patient focus of the Shalom Hospice agency and distribute these materials throughout the Service Area. Shalom Hospice will provide only the highest quality services. This is a promise to continuously work to provide the patient and family with the best service, friendliest staff and the most innovative care possible. Affinity Care was founded upon providing the best care by the best staff. Shalom Hospice will remain committed to this philosophy and to helping the terminally ill patient maintain quality of life and support family members through an extremely stressful time in their lives.

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 $179 per patient day for the first year of operation and $187 per patient day in the second year of operation.

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 2023 charges of area providers and the corresponding fiscal 2025 charges for the Applicant.

Rates by Hospice Agency within the Service Area Counties Fiscal Year 2023					
State ID	**Hospice Agency**	**Routine**	**Continuous**	**Inpatient**	**Respite**
06063/06613	Adoration Home Health and Hospice Care East TN	$203	$1,463	$1,068	$474
06603	Kindred Hospice	$183	$1,293	$970	$432
19694	Avalon Hospice	$193	$1,368	$1,016	$452
33603	Amedisys Hospice an Adventa Company	$153	$500	$825	$409
33643	Avalon Hospice	$190	$1,343	$1,001	$445
33653	Caris Healthcare	$190	$1,343	$1,001	$445
33673	Hearth Hospice of Tennessee	$158	$1,251	$996	$434
33613	Hospice of Chattanooga Inc	$158	$1,396	$990	$445
47602	Amedisys Hospice an Adventa Company	$139	$500	$909	$383
	Average, Licensed Hospice Agencies	**$174**	**$1,162**	**$975**	**$435**
	Average, Licensed Hospice Agencies in Service Area	**$176**	**$1,227**	**$979**	**$441**
	Shalom Hospice of Southeast Tennessee 12/24-11/25)	**$156-$198**	**$58/hour**	**$1,043**	**$465**

Source: Joint Annual Reports by Provider, Page 6, FY 2023. The range in routine is for the 1-60 day and 60+ day routine payments; the resulting average is based on mix of patients.
State ID 33643 - Gentiva Hospice replaced Avalon Hospice in the table in the 2023 JAR.

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 have a slightly higher average routine charges per day than the 9 licensed providers. Additionally, continuous care is paid on an hourly basis. The approximate $1,300 rate is derived from a 24-hour encounter; the lower rate is likely and 8 to 10 hour experience by that particular provider.

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Based on the above charges, and Medicare rates as published by CMS adjusted for geography, Shalom Hospice's Year 1 (2024-2025) is on par with the Service Area provider's average net revenue per patient day. Specifically, in 2023 the routine rate of $174 overall, or $176 for the Service Area hospices, inflated by three years to the forecasted time frame, results in $185 to $187 per day for routine days. Shalom Hospice's routine rate ranges between $156 and $198 with an average of $183.40. This is consistent with the Service Area routine rates at the existing providers. Given routine represents 98 percent of Shalom Hospice forecasts, when factoring in inpatient, respite and continuous days, its average only increases by $1 to $2 per day. Accordingly, Shalom Hospice's forecast 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 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:

Shalom Hospice is seeking Certificate of Need approval to establish a new in-home hospice agency that will target the Jewish community in Southeast Tennessee. This includes the counties of Bradley, Hamilton, Marion, Polk and Sequatchie. Shalom Hospice intends to develop a specifically Jewish hospice program to ensure that Jewish traditions, culture, religion and customs, particularly as it relates to death and dying, are respected. Shalom Hospice staff will integrate understanding of Jewish medical ethics into hospice care, and understand Jewish grief and mourning. While existing hospices in the Service Area have likely served members of the Jewish community, there is no Jewish hospice agency in existence within this Service Area. Therefore, those who wish to have a specifically Jewish hospice program where all team members ensure that Jewish aspects are integrated including traditions, culture, religion and customs, there is no access to such services.

According to the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics, the 2021-2022 Hospice Rates and Projected Need reports an excess of 2,521 hospice admissions in the aggregated five county service area at 80 percent of the statewide median. This decreases to an excess of 2,336 hospice admissions at 85 percent. This formula does not take into account specialized needs as enumerated herein. In fact, there is actually a dire and confirmed need for in-home hospice services uniquely tailored for Jewish people of Southeast Tennessee. The many letters in support of Shalom Hospice's CON Application are submitted in **Attachment 1N-2** and speak to the unavailability of and lack of access to Jewish Hospice in the Service Area. Approval of Shalom Hospice of Southeast Tennessee to establish a Jewish focused in-home hospice will be a significant Consumer Advantage and Benefit.

Its education and outreach plan for the underserved Jewish population are discussed in the submitted CON Application and other criteria within this Attachment. The Applicant has developed specific initiatives that will enhance hospice utilization amongst the Jewish terminally-ill population. In terms of the education and outreach programs discussed, anyone is welcome to attend these programs, regardless of religious affiliation. This includes but is not limited to providers, referral sources, congregants, families and patients.

It is also Shalom Hospice's and its affiliates' experience, which was documented in its Middle Tennessee CON application, that there are mixed religion couples and households. It is an important part of Shalom Hospice's efforts to educate spouses, children or extended family members, many of whom may not be Jewish.

In reaching out to physicians, nursing homes and assisted living facilities – in addition to the Jewish congregations – Shalom Hospice affiliates in Tennessee are currently receiving referrals of non-Jewish patients. In fact, for some referrals, until Shalom Hospice initiates its patient assessment, it is not aware of the patient's religion. It responds equally to all referrals. As stated in this CON Application, Shalom Hospice of Southeast Tennessee will not discriminate against any patient seeking to be admitted to its hospice.

Of note, the Applicant will admit any patient who is clinically appropriate and hospice eligible, regardless of their religion, age, disease, race, gender, sexual orientation and ethnicity. In terms of ensuring all eligible patients will be served equally, Shalom Hospice of Southeast Tennessee will have admission criteria in place (see Attachment 1N–6) that define hospice patient eligibility. This will be applied equally to all patients being referred to Shalom Hospice. The Applicant will serve patients equally throughout the five-county service area. Furthermore, its needs analysis referred to herein demonstrates there is limited access for the Jewish population in the defined Service Area.

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:

Shalom Hospice's affiliate hospice programs have significant experience providing services to Medicaid and medically indigent patients throughout the country. In addition to its direct commitment to these underserved population groups, the Applicant's affiliates have historically partnered with key community organizations to ensure the medically indigent and medically underserved are cared for and have access to hospice care. Affinity Health works with homeless patients and community resources to place patients in safe environments where they can receive care at the end of life.

Shalom Hospice will provide similar care to its patients in the Service Area. It will admit patients to the program, regardless of their ability to pay. The local hospitals and the area residents will also share in the cost savings and reduced hospital readmission rates as a result of greater hospice access in a timely manner. Additionally, Shalom Hospice will deploy its Continuum Palliative Resources Program, an advanced disease management program that provides palliative care to patients who are not yet terminally-ill. This palliative care program reduces hospital readmission rates by actively managing the symptoms of the patient.

As it relates to the targeted Jewish population that is the emphasis of this agency, the Applicant will also partner with the Jewish Cultural Center, Jewish Federation, and local congregations that have constituents and members in need of assistance and outreach. From a quantification standpoint,

within Question 3N it is identified that 12.4 percent of the Service Area population is below the poverty level and 19.5 percent are TennCare enrollees. This includes Jewish persons as a subset of the total population counts. Shalom Hospice will seek to support these medically indigent population equitably as with all other patients. The Shalom Hospice (Middle Tennessee) Charity Care Policy is supplied in **Attachment 1N-5**. A similar policy will be adopted by Shalom Hospice of Southeast Tennessee.

The Applicant has an affiliated foundation which also accepts donations for the care of the medically indigent. The Applicant will assure any funds raised in Southeast Tennessee are deployed for indigents within this region. Additionally, the Applicant anticipates that it will admit indigent patients for which it will receive no reimbursement. While financial feasibility is no longer a consideration under the criteria, as presented in the revenue chart in response to question 6C, Shalom Hospice expects approximately three percent of its patients will be indigent and qualify for charity care.

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:

Shalom Hospice will be licensed by the Tennessee Health Facilities Commission/Licensure Division and will be certified by Centers for Medicare and Medicaid Services. The Applicant will provide all required core components of hospice care set forth by Medicare Conditions of Participation.

Shalom 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 60 days of licensure. With respect to Shalom Hospice in Middle Tennessee, this occurred within less than 45 days of initiation of services (60 - 70 days after licensure), and it was another deficiency free survey. This documentation is included in **Attachments 5C.** With respect to Shalom Hospice in Greater Knoxville, it had its deficiency free licensure survey in December 2023. Once eligible for its CHAP accreditation survey, CHAP was informed however it was delayed until early April 2024, approximately 100 days after licensure, and was another deficiency free survey. This documentation is also included in **Attachments 5C.** The same would be expected in Southeast Tennessee.

By becoming Community Health Accreditation Program (CHAP) accredited, the Applicant will objectively validate the excellence of its community-based practice through consistent measurement of the delivery of its quality services.

Shalom Hospice will address the Jewish end of life needs of Jewish patients by becoming the first hospice agency in Southeast Tennessee to become accredited through the National Institute for Jewish Hospice. This accreditation provides staff training on the cultural beliefs and sensitivities so that the hospice provider can better serve the Jewish terminally ill. Only 1 percent of hospice programs in the United States are NIJH accredited. In Tennessee, there is one hospice in the Memphis area that has attained this accreditation as has Shalom Hospice in Middle Tennessee within weeks of receiving its CHAP accreditation (February 2023) and Shalom Hospice of Greater Knoxville (January 2024).

Shalom Hospice promises to provide only the highest quality services. This is a promise to continuously work to provide the patient and family with the best service, friendliest staff and the most innovative care possible. Shalom Hospice and its affiliate Affinity Care agencies were founded upon providing the best care by the best staff. Each day team members promise to keep each patient and their family informed and comfortable and promise the most up-to-date technology and the best of each team member's ability. Each team member is wholeheartedly committed to the same Affinity Health Pledge:

- Hospice affirms life.
- Hospice recognizes dying as a process and so our care provides comfort rather than cure.
- Hospice neither hastens nor postpones death.
- Hospice provides physical, emotional and spiritual care to terminally ill persons and their families.
- Hospice helps the terminally ill person maintain quality of life and helps family members through an extremely stressful time in their lives.

Affinity Health has a National Clinical Director and Director of Quality and Compliance who is committed to excellence. Her role is to oversee patient satisfaction, Hospice Item Set (HIS) compliance, and Quality Initiatives. This also includes helping staff to achieve excellence through training, monitoring, support and acknowledgment. Shalom Hospice is committed to providing the highest level of care and will have a designated Quality Director to conduct quality assessments, monitoring, and report all issues to senior management.

CHAP Accreditation

All Affinity Health hospice programs are accredited by CHAP. It is the intent that every Affinity Health affiliate program 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. Each Affinity Health program undergoes an arduous accreditation process by CHAP to become accredited.

Affinity Care entities all seek CHAP accreditation which is also the CMS licensing/certification entity with deeming authority for hospice services. All operational affiliates are licensed and accredited. The affiliates have a history of successfully achieving CHAP accreditation, mostly with no deficiencies. The few which had deficiencies were not condition level and were quickly corrected as it involved documentation. The affiliates also pride themselves on zero deficiencies on initial licensure surveys. Shalom Hospice in Middle Tennessee had zero deficiency licensure survey and zero deficiency CHAP accreditation survey. Shalom Hospice of Greater Knoxville also had zero deficiency licensure survey and zero deficiency CHAP accreditation survey. This documentation is included in **Attachment 5C**.

With respect to the National Palliative Care Registry for Hospice Projects, it is Shalom Hospice's intent to evaluate this registry for participation after CON approval and licensure.

As noted above, Shalom Hospice of Southeast Tennessee 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 60 days of licensure. By becoming CHAP accredited, the Applicant will objectively validate the excellence of its community-based practice through consistent measurement of the delivery of its quality services.

NIJH Accreditation

Shalom Hospice will address the Jewish end of life needs of Jewish patients. It will become the first hospice agency in Southeast Tennessee to become accredited through the National Institute for Jewish Hospice. This accreditation provides staff training on the cultural beliefs and sensitivities so that the hospice provider can better serve the Jewish terminally ill. Only 1 percent of hospice programs in the United States are NIJH accredited. Shalom Hospice in Middle Tennessee was CHAP certified in early February 2023 and received its NIJH accreditation later that month, in February 2023. Shalom Hospice in Greater Knoxville was CHAP certified in April 2024 and received its NIJH accreditation prior to that in January 2024. Copies of these accreditation certificates are included as **Attachment 4N**.

Additionally, Mr. Stern and the rest of Affinity Care's officers (Financial, Compliance, Palliative, etc) have received training and accreditation by NIJH. Furthermore, Affinity Care's triage team, on-call nurses and compliance team have all received NIJH training and accreditation as part of the home office to enable each of them to be responsive to any patient throughout the Affinity Care network, including Shalom Hospice of Southeast Tennessee once operational. Its accreditation certificate is also included in **Attachment 4N**.

The National Institute for Jewish Hospice (NIJH) began in 1985 by Rabbi Maurice Lamm. He was the first Orthodox rabbi on the board of the Jewish Federation in Los Angeles. He traveled to hospices around the country to train hospice team members to care for the dying Jewish population in their communities. Today, NIJH hosts conferences whereby staff members attend comprehensive training. Through the NIJH training, staff members gain enhanced understanding of Jewish culture and religion, and their impact on death and dying. This enables them to then integrate understanding of Jewish medical ethics into hospice care and understand Jewish grief and mourning. During these educational sessions, staff members are trained to understand all aspects of Jewish Heritage & Holidays, Jewish Medical Ethics and The Final Journey — Death, Burial and Mourning. Further, they are given vidui cards, Jewish living wills, explanation of the tahara process and an explanation of the custom to use a plain wooden coffin. Accredited agencies are given many materials like the book Prayer and Hope written by Rabbi Lamm with Rabbi Bulka.

All team members at Shalom Hospice will be trained and educated on the topics covered by NIJH. Additional information on Shalom Hospice's initiatives to serve the Jewish population in the Service Area is presented herein and information from NIJH is supplied in **Attachment 1N-6**.

Chayim Aruchim

Another dimension of the Shalom Hospice program is to ascribe to Chayim Aruchim. Chayim Aruchim – The Center for Culturally Sensitive Health Advocacy and Counseling, a project of Agudath Israel of America, was created in 2010 to help the Jewish community make end of life health care decisions

according to their religious beliefs. The mission of Chayim Aruchim is dedicated to helping members of the Jewish community make end-of-life health care decisions in keeping with their religious beliefs and according to halacha. With a team of halachic authorities, legal experts, medical, patient and pastoral care professionals and high-level government policy advocates, Chayim Aruchim endeavors to serve as a vital resource in championing, promoting and ensuring the implementation of preferences of Torah observant patients' care decisions in compliance with halacha. Shalom Hospice will incorporate the Halacha Medical Directive[2], a copy of which is supplied in **Attachment 1N-17**.

Service Intensity

There are several characteristics of Affinity Health hospice programs that distinguish it from the other hospice programs. But most significant, Affinity Health prides itself on its service intensity, which far surpasses NHPCO guidelines for staffing. If awarded this CON, Shalom Hospice will introduce a level of service that extends beyond what is currently available in this market. These operational processes will provide consumers with distinct programmatic advantages, consistent with consumer advantages outlined in the current CON criteria.

First, every new patient at Shalom Hospice will be engaged within two hours of referral, seven days a week. The two-hour turnaround time is a testament to Shalom Hospice's dedication to serving the needs of any and all hospice appropriate patients. Many hospice organizations will tell a caller on a Saturday that someone will be out to see the patient on Monday. Shalom Hospice will engage that patient within two hours. The Applicant will provide triage coverage 24 hours a day, 7 days a week, and physical visits to assess hospice eligibility of patients and admission regardless of ability to pay (charity patients).

Second, Shalom Hospice patients will be visited by a certified nursing assistant (CNA) 5 to 7 days per week which will enable the Applicant to recognize changes in the patient ahead of the curve and be proactive rather than reactive. This will assist in providing more comfortable outcomes for the patient and dually prevent unnecessary hospitalizations. The 5 to 7 visits weekly are an enormous benefit not only for the patient but for facilities/families in which the patients reside as it focuses specifically tailored hospice care for those patients on service and also provides education and training for the family or facility staff on special hospice related needs for these patients.

A third service intensity feature that will be employed by Shalom Hospice is that a registered nurse will visit every patient at least two times weekly, and daily if the patient is actively passing to provide symptom management and proper planning.

Lastly, Shalom Hospice will provide a social worker and chaplain (if the patient and family want a chaplain visit) at least weekly, which helps to keep families and loved ones well supported. The support can be a preventative measure so as not to have a crisis at the end of life resulting in a hospitalization or the patient being moved to an inpatient unit. The social worker and chaplain work vigorously to support the family so they are adequately prepared.

Reflective of Shalom Hospice's commitment to provide a service intense program, the Applicant will provide the following minimum core staffing and operational activities:

[2] The "Halachic Medical Directive" is designed to help ensure that all medical and post-death decisions made by others on the patient's behalf will be made in accordance with Jewish law and custom (halacha).

- The Applicant will provide triage coverage 24 hours a day, 7 days a week, and physical visits to assess hospice eligibility of patients and admission regardless of ability to pay (charity patients).

- The Applicant will assure each patient has 5 to 7 Home Health Aide visits per week, provided this is acceptable to the IDT, patient and family.

- The Applicant will assure each patient has a minimum of 2 RN visits per week, provided this is acceptable to the IDT, patient and family.

- The Applicant will seek to respond to all its referrals within one hour, initiate the assessment process within two hours, and expedite admission to the hospice subject to having a physician order in hand and the patient/family selecting the hospice option.

All of the above reflect the Applicant's commitment to going above and beyond in serving terminally ill residents and their families. These are indicative of Shalom Hospice's commitment to quality in its end of life programming. It is further commitment to assure consumer advantages in the approval and licensing of Shalom Hospice resulting in enhanced availability and accessibility.

In an effort to compare the above commitment to the existing providers, it should be noted that the other hospice agencies do not 'report' staffing ratios. However, available information in the Joint Annual Reports enables computation of staffing ratios for some providers, if reported. Home Health Aides appear to be a category that is fully reported. Shalom Hospice's ratio of 8 patients per Aide surpasses each provider individually and in aggregate as reflected in the following table.

Agency	Home County	Patient Days	Average Daily Census	Aides, Full Time	Aides, Part Time	Aides, Total (FT + 50% PT)	Ratios of Patients per Aide
Home Health Care of East Tennessee, Inc,	Bradley	73,878	202.4	10.0	0.0	10.0	20.2
Kindred Hospice	Bradley	25,926	71.0	6.0	0.0	6.0	11.8
Avalon Hospice	Davidson	546,515	1,497.3	117.0	0.0	117.0	12.8
Amedisys Hospice An Adventa Company	Hamilton	118,162	323.7	17.0	2.0	18.0	18.0
Gentiva Hospice	Hamilton	1,653	4.5	0.0	0.0	0.0	n/a
Caris Healthcare	Hamilton	28,039	76.8	4.0	1.0	4.5	17.1
Hearth Hospice	Hamilton	113,265	310.3	18.0	0.5	18.3	17.0
Hospice of Chattanooga Holdings, LLC	Hamilton	102,281	280.2	17.0	1.5	17.8	15.8
Amedisys Hospice An Adventa Company	Knox	313,327	858.4	31.0	8.0	35.0	24.5
Service Area Providers, Total		1,323,046	3,624.8	220.0	13.0	226.5	16.0
Shalom Hospice of Southeast Tennessee	**Hamilton**	**10,235**	**28.0**	**3.5**	**--**	**3.5**	**8.0**

Source: Joint Annual Report Master File, 2023 for the respective providers.

In addition to the home health metrics, we undertook an analysis of RNs (including part time RNs). In total among the existing providers, there were 363 full time and 40 part time RNs. At 50 percent time for a part time worker, total RN employees are estimated to be 383. With an average daily census of 3,625 as reflected in the above table, that equates to 9.5 patients per RN. Shalom Hospice has budgeted a ratio of 10 patients per RN plus a floater plus and on-call RN. Including the floater and on-call RNs, the ratio equates to 8 patients per RN. At these levels, Shalom Hospice out-performs the service area in RN staffing in addition to home health aide staffing.

Additionally, social worker staff are identified. In total among the existing providers there were 75 full-time and 4.5 part-time social workers. With an average daily census of 3,625 as reflected in the above table, that equates to 47 patients per social worker. Shalom Hospice has budgeted a ratio of

25 patients per social worker. At this level, Shalom Hospice out-performs the service area in social worker staffing.

Music Therapy

Music therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a board-certified music therapist (MT-BC). Research in music therapy supports the effectiveness of interventions in many areas such as facilitating movement, increasing motivation, providing emotional support for clients and their families, and creating an outlet for expression of feelings. Because music therapy is a powerful and non-threatening intervention in medium, unique outcomes are possible.

In practice, music therapy in hospice has been shown to accomplish a number of goals, including the following:

- Pain Management
- Anxiety Reduction
- Improving Comfort
- Expression of Emotion (Verbally and Non-Verbally)
- Increasing Feelings of Meaning & Purpose
- Resolving Family Conflict/Relational Stress
- Processing Grief-Related Feelings and Experiences
- Increasing Self-Esteem/Self-Acceptance
- Increasing Range of Coping Mechanisms
- Enhancing Quality of Life
- Gaining a Sense of Spiritual Support
- Fostering Meaningful Sensory Engagement
- Creating Positive Memories at the End of Life

Music therapy treatment is efficacious and valid with older persons who have functional deficits in physical, psychological, cognitive or social functioning. Research results and clinical experiences attest to the viability of music therapy even in those who are resistive to other treatment approaches. Music is a form of sensory stimulation, which provokes responses due to the familiarity, predictability, and feelings of security associated with it.

Music therapy goals are to reduce the amount of suffering patients may be feeling, creating a space for more social interaction. It can create a peaceful and calming environment. Oftentimes patients may be struggling during the end of life. But music therapy allows them to remove themselves from that struggle for a short period of time and really immerse themselves into the music and the therapeutic motion it brings to the patient. Because music has a universal power to affect emotions, Affinity Care leadership felt strongly that music therapy should be a core service in each and every affiliate program at the outset.

When Affinity Care music therapists go for a visit, they assess the strengths and needs of each client. They develop a treatment plan with goals and objectives and provide the indicated treatment. Music therapists structure the use of both instrumental and vocal music strategies to improve functioning or facilitate changes that contribute to life quality. They may improvise or compose music with clients, accompany and conduct group music experiences, provide instrument instruction, direct music and movement activities, or structure music listening opportunities. For those who are unable to speak, they may just engage through eye contact or a smile.

Music can make the patients' eyes light up and it brings a smile to everyone's face. It is truly powerful to see patients' reaction to music therapy. Patients who do not normally speak will end up singing along with the music because something triggers in their brain when they hear it. Music therapy at Affinity Care gets the patient to open up and engage in a life review. Music, by its very nature, brings people together and a host of memories associated with the music. The music the therapists play can bring families together so they can reminisce and transport to a happier time.

Affinity Care wants patients and their loved ones to have these experiences. Therapists attempt to get patients to speak about their memories to bring happiness and closure at the end of life. Music therapy is a very powerful tool for hospice. It truly has a lasting impact on the patient, their family and hospice staff. Affinity Care brings to patients at the end of life those things that really bring comfort and happiness, with music being a primary tool.

All Affinity Care music therapists achieve Music Therapist – Board Certification. Graduates of colleges and universities from more than 70 approved music therapy programs are eligible to take a national examination administered by the Certification Board for Music Therapists (CBMT), an independent, not for profit certifying agency fully accredited by the National Commission for Certifying Agencies. After successful completion of the CBMT examination, graduates are issued the Music Therapist-Board Certified credential that is necessary for professional practice. Any individual who does not have proper training and credentials is not qualified to provide music therapy services.

Shalom Hospice, as with all Affinity Care affiliates, will employ music therapists based on 1 music therapist for an average daily census (ADC) of 50 patients. This is very meaningful as other hospices who provide 'music therapy' often utilize volunteers for this program or employ 1 music therapist for the entire program regardless of ADC. Having certified therapists in sufficient numbers to regularly provide this therapy will be greatly beneficial for residents of the Service Area. Shalom Hospice will initiate this program upon licensure.

Please see the Affinity Health Hospice Music Therapy video link (https://affinityhealthmanagement.com/music-therapy) as well a sample Music Therapy policy and procedure which are provided behind **Attachment 1N-6.**

Virtual Reality Program

The Virtual Reality Program was deployed at Affinity as a result of the organization's culture and mission to provide non-pharmacological interventions to help with the experience of its patients and families. Virtual reality is a technology that allows a person to put a headset on and go anywhere in the world. At Affinity Care there are two different elements of the Virtual Reality Program. The first is the Patient Virtual Reality Program which is where the patient wears the headset and has the experience. The other element is the Community Virtual Dementia Tour.

The Community Virtual Dementia Tour is provided to patient families and community facilities (e.g., nursing homes and assisted living facilities), to give them a virtual tour of Patients with Dementia. Patients with Dementia helps those families and clinical staff experience the challenges faced by the patient to help foster understanding and sensitivity to the care needs of the patient.

The Patient Virtual Reality (VR) Program brings a larger world to those who have found themselves limited to a room, or just a bed. It can be a way to check off bucket list items, like visiting Ellis Island or Jerusalem, swimming with dolphins or even skydiving. It can also complement therapy and counseling, and even help manage pain. The goal of this program at Shalom Hospice is to allow staff

to provide a patient with an experience they never would have had with another hospice agency. The VR in hospice helps the patient and their loved ones with depression, anxiety, relive experiences and provide them with memories from their bed.

One such example of an Affinity affiliate patient's Virtual Reality experience is a gentleman who presented in the hospital emergency room with a fractured hip and who had terminal cancer. He told his hospice Chief Nurse Educator that he was supposed to be getting on a last cruise with his wife, to Alaska, that day. Once this patient returned home from the hospital, the Chief Nurse Educator visited the couple. Using two virtual reality headsets and a Google Earth virtual reality experience she had developed; she was able to give the couple an experience they thought they would never be able to have. She gave them one last trip together. The Chief Nurse Educator plotted out the cruise ports for the couple who missed their trip. The man's wife reported that he told everyone who came to visit him about his VR experience. When he died, she even talked about their last trip at his service. Instead of being in bed, waiting to die, he found he was able to live and participate and find enjoyment each day that he was given.

All patients are assessed during the intake process and throughout their care by the care team for the benefits of the Virtual Reality Program. VR goggles are provided by Rendever as well as the tablets for the staff to guide experiences. An estimated 95 percent of Affinity patients have utilized virtual reality. With respect to Shalom Hospice in Middle Tennessee, 100 percent of its patients who are able have utilized virtual reality. And, in the newly operational Shalom Hospice of Greater Knoxville, approximately half to date of its patients who are able have utilized virtual reality.

A new addition in response to Shalom Hospice's emphasis on serving Jewish patients, is a Jewish hospice virtual reality experience. Shalom Hospice and Rendever created a special virtual reality platform for the Jewish population that honors the history and plight of the Jewish experience and provides "travel" to religiously significant sites and experiences throughout the world. This Jewish hospice virtual reality program is utilized by patients of Shalom Hospice. Programs include the following:

- Arch of Titus and Jewish ghettos in Middle Ages, the Altneu Synagogue in Prague with image of Golem in background;
- Jewish shtetls in Poland, Galicia, Russia, Ukraine;
- Persecution of Jews during the Holocaust with an experience around the Liberation of Auschwitz by American soldiers with video of American Jewish soldiers connecting with concentration camp survivors;
- Historical footage of Jewish immigrants arriving in Ellis Island with Statue of Liberty in background combined with current day 360° footage and voiceovers.
- Lower Eastside with its Jewish peddlers, dry goods businesses, delis, etc. reflecting Jewish experience, culminating in Joe Lieberman's candidacy for Vice President;
- Modern Israel including the Tel Aviv skyline, Dizengoff Circle, and Jerusalem's various neighborhoods, including Mea Shearim, King George and King David Street;
- Modern Jewish life in America, including 770 Eastern Parkway headquarters of Chabad movement, some other Jewish neighborhoods such as Brooklyn, suburbia like Monsey or Teaneck with snippets of Jewish campus life, and potentially including visibly Jewish doctors, lawyers, etc.

Given that the programming and implementation was previously completed, it will be available for deployment by Shalom Hospice of Southeast Tennessee upon licensure.

Please review the Affinity Care Hospice Virtual Reality Program video links -- https://youtu.be/dAlPcRxI1CM and, https://affinityhealthmanagement.com/what-is-virtual-reality/ for a thorough understanding of this innovative technology. In addition, please review the CNet.com article on its Virtual Reality Program titled, "How families are giving a fantastic trip to loved ones in hospice" provided in Supporting Documents to this CON Application. Additionally, see the following link -- https://www.cnet.com/videos/bucket-lists-get-checked-off-in-vr/ for a clip from a PBS program which highlighted affiliate, Continuum Care of Mass, and its use of Virtual Reality. This clip demonstrates an affiliate program putting action to their commitment to provide Virtual Reality to its patients.

Equine Therapy

Equine Therapy is an experiential therapy that combines the power of the human-horse relationship and Gestalt Therapy. Research suggests that engaging with horses benefits humans, indicating an enlivened state without stress. The research supports that older people become more aware of their bodily sensations and emotions, leading to increased heart rate variability, improved self-esteem, and improved immune function. Horses give immediate feedback to the handler or rider's actions and they have the ability to mirror the feelings of the handler or rider. Because of their large and intimidating appearance, it encourages an individual to gain trust around them. Horses invite people to experience deeper awareness of their strengths and areas of their life that need support. A 2018 study titled "Effects of a Form of Equine-Facilitated Learning on Heart Rate Variability, Immune Function, and Self-Esteem in Older Adults" is supplied in **Attachment 1N-6.**

Affinity Health 's use of equine therapy is a successful representation of the neuroscience and relationship model to help patients realize their highest level of healing at the end of life. Because horses have the ability to sense energy from 300 feet around them, they have been shown to effectively treat patients who manifest depression, dissociative disorders, anxiety, dementia, cancers, and many more emotions.

Patients and their caregivers, who are able to travel to the equestrian farms (wheelchair vans are provided by Affinity Health), spend time with a Certified Equine Therapist (CET). Prior to the session beginning, the CET will provide the patient with safety and information. At the beginning of the session, the CET will ask the patient what their intention is for the day's session. Next, the CET will introduce the patient to the horse and allow the horse and patient to discover each other. The natural senses from the horse draw them into the patient where they connect through touch. The patient may choose to stand next to the horse. Others will brush and massage, groom or talk to the horse. Through non-verbal communication, the patient and horse can develop a connection. Following a session, patients in pain report feeling better. When the person relaxes the horse will do the same. The effect on a patient's face is palpable.

This program has seen the highest success rates from patients that have the most difficulty communicating with other humans and have the above-mentioned disorders. The Equestrian Therapy program was started by Continuum in Rhode Island, and adopted as part of a pilot project which has shown remarkable success. Not only did patients benefit, but also caregivers and survivors who attend monthly bereavement clinics at the Washington County (RI) Stables benefit. After reviewing the initial data from Rhode Island, the other Affinity Care programs initiated equine therapy where access to horse farms was possible within the service areas.

Given the availability of qualified horse farms in Southeast Tennessee, Shalom Hospice will develop an equine therapy initiative. Upon CON approval, Shalom Hospice will initiate collaborative

discussions with local equine therapy stables in the Service Area. Once an agreement(s) is in place, equine therapy will be prescribed and included as part of the patient's hospice care plan.

The Therapist will use the Edmonton Symptom Assessment Scale prior to Equine Therapy and post therapy to determine the effectiveness of the treatment for patients. Pain score reductions of 25 percent or greater, with greater than 80 percent sense of well-being improvements are common indicators of the success of the program. Shalom Hospice will offer Equine Therapy to its patients once Medicare certified. Please refer to the equine therapy video at the following link: https://affinityhealthmanagement.com/what-is-equine-therapy/ for an informative guide to Affinity Care's equine therapy patient experience.

Continuum Palliative Resources

Another quality initiative that is an attestation to Shalom Hospice's commitment to quality is Continuum Palliative Resources. Continuum Palliative Resources is an advanced disease management program for patients who are at a maximum therapy level and approximately 24 months from the end of life. Continuum Palliative Resource's model of care is designed to encompass the body, mind and spirit of patients with advanced diseases. It focuses on three of the biggest diagnosis groups which have the highest implication of re-hospitalization, highest regulatory scrutiny, and the highest impact financially to payors. They are referred to as the 3C's: cancer, congestive heart failure and chronic obstructive pulmonary disease (COPD). Though patients with other advanced diseases are treated in this program, the 3C focus has produced the highest level of improved outcomes.

Though Continuum Palliative Resources is a separate and distinct program from Shalom Hospice, and from Affinity Care hospices, it has been offered in each market where Affinity Care has already obtained its Medicare certification. Within approximately six months of receiving hospice Medicare certification in its existing hospice programs, affiliates commence establishing a palliative care program to work alongside its hospices. To commence a program, the affiliate files with Medicare to receive a Part B number to enable palliative care billing. In Middle Tennessee – after its certification, it applied to Medicare to receive its Part B number to commence providing palliative care services in Middle Tennessee. The Middle Tennessee palliative program is currently servicing patients. The Knoxville palliative care program is expected to commence services by fall 2024 using the same provider number that was sought by the Middle Tennessee program.

Additional examples of palliative care programs operated by the applicant's affiliates include programs in Florida, Washington, New Jersey, Ohio, Pennsylvania, Missouri, Virginia, Maine, Indiana and Oklahoma. One example to highlight, Shalom Hospice's affiliate in Virginia, Affinity Palliative of Virginia, LLC, began providing palliative care at Henrico Doctors Hospital mid-August 2021. The program was so successful in reducing mortality rate, reducing length of stay, and reducing hospital readmissions, in addition to reducing patients perceived rate of pain, that HCA (Henrico Doctors Hospital's owner) quickly extended its agreement with Affinity Palliative of Virginia to implement this program at its other two Richmond, Virginia hospitals, Parham Doctors' Hospital and Retreat Doctors' Hospital.

This investment in its palliative care program will greatly benefit the Shalom Hospice's Service Area. Continuum's Palliative Resources Programs are linked with hospitals and managed care providers. As such, there are frequent meetings, some as often as weekly, to discuss the patient's care plan and identify risks and needed changes to keep patients at home. Medication adjustments, therapy introduction and social service needs are being addressed faster resulting in better medical management. Palliative care is not a CON regulated service but rather a service billed under Medicare's Part B program as an outpatient visit.

Shalom Hospice's commitment to implement an affiliated palliative care program and work collaboratively with healthcare providers throughout the Service Area will have a significant benefit to the patient and to reducing hospital readmission rates and preventable visits. The Continuum Palliative Resources has an enormous benefit for the communities where it is made available. The palliative care program, in conjunction with Shalom Hospice, will provide the following benefits:

- Improve communication between hospitals, skilled nursing facilities, primary care physicians, and specialists that result in positive outcomes for patients.
- Improve medication management which would have otherwise led to unplanned emergency room visits and/or re-hospitalizations.
- Ongoing patient and caregiver education on disease progression, alternative medical services available, expectations as disease progresses, how to manage symptoms, knowing when to call the physician.
- Identify goals of care and decreasing patient and caregiver anxiety by encouraging difficult conversation with patients nearing end of life about what they really want.
- Serve as a connection to the community for resources to assist in providing additional services that can aid in transportation, food services, facility placement, spiritual care, amongst others.
- Reduce the patient's propensity to use hospital and/or emergency department as their medical manager, and reinforce better options.
- Decrease cost of care as patients near end of life.

A brochure on Continuum Palliative Resources is provided in **Attachment 1N-6.** The Continuum Palliative Resources program will be implemented within six months of Shalom Hospice receiving its Medicare certification. This program will provide patients with relief from symptoms and pain, supporting the best quality of life, before the patient terminates treatment and qualifies for hospice. This will significantly improve the perception of hospice, repair the negative image hospice historically has amongst minorities and help to develop an end-of-life care plan designed for the individual.

Quality Assurance Performance Improvement Plan

Shalom Hospice will develop and maintain a Quality Assurance Performance Improvement (QAPI) Plan similar to those in place at its affiliate programs. The purpose of Shalom Hospice 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, Shalom 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.

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 Shalom Hospice staff members

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:

- Identifying trends in clinical outcomes
- Evaluating data related to systems and services offered to patients
- Monitoring new systems and services
- Monitoring customer and patient satisfaction

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
- The committee will focus on significant areas of improvement each month
- The committee will track progress of agencies performance improvement plans
- Confidentiality will be maintained
- Only trended information, no patient specific information, will be communicated outside the QAPI Committee
- Committee will track and analyze adverse patient events
- Agency staff will be kept informed of PIPs and involved in QAPI process

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.

Shalom Hospice (Middle Tennessee) Quality Improvement Plan is included in **Attachment 1N-6** as a sample. A similar QAPI Plan will be adopted and maintained by Shalom Hospice of Southeast Tennessee.

Shalom Hospice will provide only the highest quality services. This is a promise to continuously work to provide the patient and family with the best service, friendliest staff, and the most innovative care possible. In terms of quality metrics, Medicare provides an objective measure to assess quality of care for hospice operations. The collection of the data was temporarily halted during the COVID pandemic but collecting and publishing of this information restarted in 2021. Affinity's operational affiliates demonstrate excellent quality metrics using the HIS Quality Measures. These eight measures roll up into a hospice wide HIS score provided on the CMS website.

The Affinity hospice affiliates contract with data vendor SHP to gather their survey data and submit it to CMS. Given this extensive engagement with SHP, the affiliate enterprise (roll up of all hospices within the organization), SHP can produce Enterprise-Wide scores for the affiliates of Affinity. The

most recent scores (Q1 2024) rolled up for the Affinity affiliates, compared to the states within which it operates, and national benchmarks are provided in the following table:

HQRP Process Measure Analysis

Affiliate Enterprise Experience vs State and National Benchmarks

Meaure:	Affiliate Enterprise	MultiState	National
Comprehensive Assessment at Admission	100.0%	97.90%	97.92%
Treatment Preferences	100.0%	99.93%	99.92%
Beliefs/Values Addressed	100.0%	99.59%	99.62%
Pain Screening	100.0%	99.48%	99.51%
Pain Assessment	100.0%	99.00%	98.97%
Dyspnea Screening	100.0%	99.74%	99.63%
Dyspnea Treatment	100.0%	99.30%	99.36%
Patients Treated with an Opiod who are Given a Bowel Regiment	100.0%	99.30%	99.34%
Source: SHP Enterprise reporting, January 1, 2024 through March 31, 2024			
Note: Green indicates exceeds state and national benchmarks.			

In all categories, Affinity affiliates score 100%. This exceeds the state averages in which it operates as well as national averages.

Each of the Affiliates rolled up in the above scores would have to also achieve 100% across the entire company to have a roll up percent of 100 percent. Notably, this is not just one or two hospices and one or two states. It represents many hospices across many states. The individual scores by hospice agency for 2023 are presented in the first table on the following page. The Q1 2024 scores for the same affiliates are provided in the second table on the next page. In conclusion, the Applicant's affiliates have excellent metrics as measured by Centers for Medicare and Medicaid Services (CMS) Hospice Item Set.

Another measure by CMS is the Hospice Care Index (HCI). HCI captures care processes occurring throughout the hospice stay, between admission and discharge. The HCI is a single measure comprising ten indicators calculated from Medicare claims data. There are ten affiliated hospices with HCI scores, 7 of them with a 10 (perfect score) and 3 with a 9, averaging 9.7 across the company. This compares with a national average of 8.8. This information is provided in the third table on the next page.

Lastly, another CMS quality metric addresses the last 3 days of life of a patient and the percent of patients who received visits from a registered nurse or medical social worker on at least 2 of the final 3 days of life. This metric is known as the HVLDL. Affinity has 11 affiliates on the CMS website. 10 exceed the national average – 7 of them by approximately 50 percent; only one approximates the national average. These are in the also provided third table on the next page.

HQRP Process Measure Analysis
Affiliate Experience, Calendar Year 2023

Meaure:	Shalom Tennessee	Continuum Broward	Continuum Miami	Continuum Sarasota	Affinity Indiana	Affinity Maine	Missouri	Affinity NJ Brick	Affinity NJ Parsippany	Ohio West Chester	Ohio Monroe Falls	Affinity Oklahoma	Affinity PA	Affinity VA	Continuum Snohomish	Continuum King	Affinity DC	Affinity GA
Comprehensive Assessment at Admission	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Treatment Preferences	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Beliefs/Values Addressed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Pain Screening	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Pain Assessment	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dyspnea Screening	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dyspnea Treatment	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Patients Treated with an Opiod who are Given a Bowel Regiment	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: SHP Enterprise reporting, January 1, 2023 through January 31, 2024

Note: Green indicates exceeds state and national benchmarks.

HQRP Process Measure Analysis
Affiliate Experience, January 2024 through March 2024 (Q1 2024)

Meaure:	Shalom Tennessee	Continuum Broward	Continuum Miami	Continuum Sarasota	Affinity Indiana	Affinity Maine	Missouri	Affinity NJ Brick	Affinity NJ Parsippany	Ohio West Chester	Ohio Monroe Falls	Affinity Oklahoma	Affinity PA	Affinity VA	Continuum Snohomish	Continuum King	Affinity DC	Affinity GA
Comprehensive Assessment at Admission	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Treatment Preferences	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Beliefs/Values Addressed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Pain Screening	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Pain Assessment	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dyspnea Screening	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dyspnea Treatment	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Patients Treated with an Opiod who are Given a Bowel Regiment	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: SHP Enterprise reporting, January 1, 2024 through March 31, 2024

Note: Green indicates exceeds state and national benchmarks.

Quality of Patient Care - Percentage of Visits and Hospice Care Index (HCI)
Applicant Affiliates and National Rates

	Continuum Broward	Continuum Miami	Continuum Sarasota	Continuum King	Continuum Snohomish	Affinity NJ	Affinity Ohio	Affinity PA	Affinity VA	Affinity Indiana	Affinity Missouri	National Average
Percentage of patients who received visits from a registered nurse or medical social worker on at least 2 of the final 3 days of life	67.8%	70.0%	56.1%	61.9%	59.9%	69.4%	75.1%	46.2%	73.9%	66.7%	68.8%	47.9%
Hospice Care Index	10	10	10	n/a	10	10	10	9	9	9	10	8.8

Green indicates above National averages.

Source: Medicare.gov, May 2024

Continuing Education and In-Service Training

Shalom Hospice will encourage all its staff members to establish and maintain memberships in hospice organizations and to participate in continuing education courses to further ensure high quality services are provided to all patients and their families. Every Affinity Care nurse participates in continuing education credits, as will all Shalom Hospice nurses.

The Shalom Hospice In-Service Learning Manual, which also includes the company's mission, vision, goals and philosophy is included in **Attachment 1N-6.**

The Applicant will provide initial orientation, continuing education and in-service training to its staff via its online education program through Relias Learning. Relias supports the agency in its ability to deliver better outcomes by reducing variation in care. The learning management system employs analytics and assessments to reveal specific gaps in clinical, regulatory, and customer satisfaction knowledge areas. The system will allow Shalom Hospice to create comprehensive standardized training for the entire team and then to customize additional training to each individual member of the team in a personalized and engaging learning atmosphere. There are more than 650 courses for Shalom Hospice to draw upon to ensure each staff member has access to a comprehensive individualized training plan. The training plan is comprised of orientation courses and annual mandatory training selected based on job description to comply with CHAP accreditation standards, Medicare Guidelines, state specific regulations and company policy. The analytic tools will allow Shalom Hospice to identify gaps in individual's skills as well as trends that might exist within the company. Through the system Shalom Hospice will be able to build career paths and long-term educational plans to meet each employee's goals.

Courses include detailed and focused educational units on all aspects of hospice care, for all of the professional disciplines: Physicians, RNs, LPNs, CNAs, Social Workers, Chaplains, Bereavement Counselors, Volunteer Coordinators and others. Participants completing an education program online and successfully completing a post-test receive continuing education unit (CEU) credits and a certificate. Shalom Hospice will utilize the Relias system for purposes of orientation, staff and volunteer training and continuing education.

Please refer to **Attachment 1N-6** for additional documentation on each of the above quality programs and services to be provided by Shalom Hospice.

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:

Shalom Hospice will provide outreach and education to Service Area physicians, hospital discharge planners, social workers, long term care facility leadership and other healthcare providers on the importance of end of life care and, specifically, the importance for timely referral to hospice. Shalom Hospice representatives will regularly host and/or attend hospice educational events at Jewish organizations throughout the community, at local veteran's organizations, senior organizations, and area health and wellness events. Representatives will aim to educate the community on the many benefits of end-of-life care through hospice.

Shalom Hospice will also demonstrate to these area providers that not only are timely referrals important but also timely responsiveness to referrals. Shalom Hospice will institute a policy that every new patient will be engaged within two hours of referral, seven days a week. The two-hour turnaround time is a testament to Shalom Hospice's dedication to serving the needs of hospice appropriate patients and works in conjunction with educating local referral sources on timely referrals.

Please refer to **Question 4N** in the CON Form for detailed education and implementation strategies outlined by Shalom Hospice to be implemented in Southeast Tennessee. These strategies have been discussed with the Jewish community representatives and are consistent with the community and Shalom Hospice's plans on program implementation.

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 RateWhere:

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. There is a need shown for at least 100 total additional hospice service recipients in the proposed Service Area, provided, however, that every county in the Service Area shows a positive need for additional hospice service recipients.

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 2021-2022 Hospice Rates and Projected Need report, the Hospice Penetration Rate at 80 percent shows an excess of 2,542 hospice admissions in the aggregated six county service area at 80 percent of the statewide median. This decreases to 2,367 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 uniquely tailored for the Jewish people of Southeast Tennessee. The 2021-2022 Hospice Rates and Projected Need for the Service Area follows.

	Hospice Patients Served			Total Hospice Deaths*			Hospice Penetration Rate	Hospice Penetration Rate and Patient	
County	2021	2022	Mean	2021	2022	Mean	Mean Number of Patients/ Mean Number of Deaths	*0.443*	*0.471*
Bradley	890	1,010	950	1,481	1,260	1,371	0.693	(343)	(305)
Hamilton	3,961	3,524	3,743	4,163	3,888	4,026	0.930	(1,959)	(1,848)
Marion	265	329	297	440	423	432	0.688	(106)	(94)
Polk	167	181	174	321	276	299	0.583	(42)	(33)
Sequatchie	138	220	179	213	179	196	0.913	(92)	(87)
Service Area	5,421	5,264	5,343	6,618	6,026	6,322	0.845	(2,542)	(2,367)

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Death Statistical System, 2018-2022. Nashville, Tennessee. 2021-2022 JAR Hospice (not including Residential Hospice) data used for patient data, May 2024.

REVISED 50R

There are 9 licensed in-home hospice agencies serving the five-county Service Area but not one of them offers Jewish hospice services and none are accredited through the National Institute for Jewish Hospice nor ascribe to Chayim Aruchim. The need for this CON application is evidenced by the many letters of support that have been submitted in favor of a Jewish hospice program, one that will care

for Jewish patients in a manner that recognizes Jewish heritage, history and traditions. This will be a significant consumer advantage for Jewish persons residing in the Service Area.

There are estimated to be between 3,000 and 4,000 Jewish persons in Southeast Tennessee. Their households likely number greater than 4,000 when considering both Jewish and non-Jewish person residing in these households. This range was further confirmed by considering affiliate members of each synagogue in the region and extrapolating for unaffiliated families and family size. Estimates of the Jewish population by area supports that the largest Jewish group reside in Hamilton County. This is followed by Bradley, Polk, Marion and Sequatchie Counties.

The Jewish community in Southeast Tennessee is somewhat older than the national average and therefore the availability and accessibility to senior services, and end of life care, have never been more imperative for this cohort. The Jewish community in the Service Area counties currently have the following services to meet various life stage needs:

- Three Synagogues
  - Chabad Jewish Center of Chattanooga
  - B'nai Zion Congregation
  - Mizpah Congregation
- Jewish Federation of Greater Chattanooga
- Jewish Cultural Center
- Jewish Burial Society
- Aleph Bet Jewish Preschool
- Several Jewish cultural, service, and social organizations including Jew - TC, Hadassah Organization, among others

As reflective in the map shown in **Question 3N** in the CON Form, Southeast Tennessee has eight identified religious and social organizations; all are located in Hamilton County but serve residents throughout the region. Anecdotally, Jewish people in each of these surrounding counties access the organized Jewish resources in Hamilton County as they are communal gathering locations for religious services, social engagement and mission driven activities. This Jewish community is active and robust. But this five-county Service Area lacks a Jewish hospice agency. Offering programs and expanding the reach of the community will provide better service to the Jewish population throughout the Service Area.

The Applicant will fill a void in service thereby enhancing accessibility and availability of Jewish hospice services for the Jewish terminally-ill throughout the Service Area. Under Jewish rituals, the returning of one's soul to God at the end of its journey in this world is the most profound moment in a person's life. As the soul approaches eternal life in heaven, religion becomes a source of comfort and peace. Because the existing hospice agencies are not familiar with Jewish rituals and customs, they are unable to ease the spiritual anguish of the dying and their families. Shalom Hospice will fill that void.

Quantifiable need for this projected is derived from the 30 letters of support[3] for Shalom Hospice that identify the void that exists today of a Jewish hospice agency in the Service Area. These letters specifically speak to the need for a faith-based end of life provider knowledgeable and experienced in providing personalized and culturally sensitive care within the framework of Jewish law and ritual, within the Service Area counties. The outpouring of support for the project is representative of Service

[3] These letters are referenced herein; additional letters may have been sent directly to the Health Facilities Commission or will be submitted during the review period.

Area physicians, rabbis and Jewish congregations, other spiritual leaders, assisted living facilities, nursing homes and community members. The list of letter sponsors is presented below.

Physicians, Providers, Nursing Homes, Assisted Living Facilities and Home Health Agencies:

- Thomas Devlin, MD, PhD, FSVIN, CHI Memorial Neuroscience Institute, Director, Chattanooga Center for Neurologic Research LLC, Director, Neuroscience Innovation Foundation, Medical Director, CommonSpirit National Neuroscience Collaborative, Co-Director and Professor of Neurology, University of Tennessee Health Science Center
- Stephen V. Dreskin, MD, Tennessee Valley Pain Management
- Israel Franco, MD, Erlanger Urology
- Martin Simms, MD and Shelley Simms
- Karen E Hulley ACNP-BP, MSN, CCRN
- Ray Allen, Administrator, Soddy-Daisy Healthcare Center (Hamilton County)
- Lydia Sandberg, Director of Social Services, Life Care Center of Cleveland (Bradley County)
- Margaret Ferguson, Chaplain, Alexian Village Health and Rehabilitation Center (Hamilton County)
- Alicia Condra, Director of Nursing, Valley View Assisted Living (only ALF in Marion County)
- Bebe Kennedy, VP of Clinical Services, Morning Point Senior Living on behalf of its six area facilities:
    - Morning Pointe of Chattanooga
    - Morning Pointe of Collegedale at Greenbriar Cove
    - Morning Pointe of Hixson
    - Morning Pointe of Chattanooga at Shallowford
    - Morning Pointe of East Hamilton
    - The Lantern at Morning Pointe
- Ian Shives, Senior Executive Director, East Hamilton Morning Pointe (Hamilton County)
- Tess Greer, LPN, Wellness Director, Dominion Senior Living (Hamilton County)
- Sharon Scott, Resident Care Director, Regency House (Hamilton County)
- Rachel Southerland, RN, Health and Wellness Director, Brookdale Mount Vernon (Bradley County)
- Bill Tobin, Client Care Manager, Preferred Care at Home
- Savannah Burkhart, General Manager, Home Instead

Jewish Congregations and Religious Affiliated Organizations/Persons:

- Rabbi Shaul Perlstein, Chabad of Chattanooga
- Rabbi Sam Rotenberg, Rabbi at B'nai Zion Congregation
- Charles “Chuck” J. Fleischmann, Member of Congress, Tennessee Third District
- Kevin M. Spiegel, FACHE, Former CEO Erlanger Health System and Assistant Professor of Medicine, UT, Current Assistant Professor Drexel College of Medicine, President & CEO Medical Expansion Partners, Chaplain, United States Chaplain Corps
- Sarah Aronson, 911 Ambulance Driver and Jewish Burial Society
- Thomas P. Balazs, Professor – University of Tennessee, Chattanooga and Advisor, Jew-TC
- Manuel V. Mendizabal, AWR Ambassador, General Conference of Seventh Day Adventist Church, Emeritus Ordained Minister, Southern Union Conference of Seventh Day Adventist Church
- Stonewall “Stoney” Ponders, Founder, Ponder Funeral Homes

Unaffiliated Community Support

- Christine Duncan, Marion County resident
- Zachary Summit, Marion County resident

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 Shalom Hospice, others did in fact estimate the number of referrals to Shalom Hospice. These quantifiable estimates are identified below and in aggregate represent 'at least' 160 to 264 admissions per year. Qualitative need provides for incremental admissions beyond that which is quantified in these letters and is discussed throughout this CON application.

Thomas Devlin, MD, CHI Memorial Neuroscience Institute (Hamilton County)

> *"Please approve the Shalom Hospice CON application to provide end of life hospice services to my Jewish patients, the Jewish population throughout southeast Tennessee and others who will benefit from its spiritual programming. I would estimate that in any given month, we would identify between 1 and 5 patients or families who would benefit…"*

Stephen V. Dreskin, MD, Tennessee Valley Pain Management

> *"Given the uniqueness of this program, I am confident it will be a community benefit for our patients and the public at large. I would anticipate with the size of our practice, that we would identify between 1 and 4 patients per month, depending on the month, who might consider this hospice program…."*

Ray Allen, Administrator, Soddy-Daisy Healthcare Center (Hamilton County)

> *"As the operator of Soddy Daisy Healthcare Center, I strongly advocate for the approval of a hospice in Southeast Tennessee that has an emphasis on serving Jewish patients. Based on Shalom Hospice's planned programming, and our resident profile, I would expect our facility and its physicians will refer an average of at least 2 patients per month to Shalom Hospice…"*

Lydia Sandberg, Director of Social Services, Life Care Center of Cleveland (Bradley County)

> *"Their rapid response to referrals will also be welcome 7 days per week. Based on our patients and knowledge of our community, I would anticipate referrals to Shalom Hospice will likely range between 2 and 3 per month..."*

Alicia Condra, Director of Nursing, Valley View Assisted Living – the only ALF in Marion County

> *"Shalom Hospice is seeking to meet some very specific underserved needs but will also admit any hospice appropriate patient that seeks its services, whether driven by its spiritual programming, service intensity or specialty programs. Each of these facets of its proposal are of interest to us as we believe our residents when appropriate for referral will benefit from rapid response, nearly daily patient touches, spiritual programming, music therapy and virtual reality. Given our resident profile, these referrals may number 1 to 3 per quarter.*

Bebe Kennedy, VP of Clinical Services, Morning Point Senior Living on behalf of its six area facilities: Morning Pointe of Chattanooga, Morning Pointe of Collegedale at Greenbriar Cove, Morning Pointe of Hixson, Morning Pointe of Chattanooga at Shallowford, Morning Pointe of East Hamilton and The Lantern at Morning Pointe

> *" …Our reasons for this support are based on Shalom Hospice's referral response time, service intensity and spiritual programming. … With the above as Shalom Hospice's service commitment, we expect, based on our residents in our numerous facilities throughout this region, that each facility would likely have on average at least 1 referral per month. …"*

Ian Shives, Senior Executive Director, East Hamilton Morning Pointe (Hamilton County)

> *"I was also impressed with their specialty programs of music therapy and virtual reality. These are unique programs they will offer to all patients at no cost regardless of funding. Given our resident profile and community, I would expect referrals to average 1 per month…."*

Rachel Southerland, RN, Health and Wellness Director, Brookdale Mount Vernon (Bradley County)

> *". We are supportive of the HFC approving the Shalom Hospice application for several pertinent reasons which will benefit our Brookdale community. … With Shalom Hospice's service commitment as detailed above, we expect to refer at least one patient per month to Shalom Hospice. We strongly urge you to approve Shalom Hospice…"*

Bill Tobin, Client Care Manager, Preferred Care at Home

> *"…Given the geographic footprint of the market we cover and the base of clients and families we serve, I anticipate that we would enjoy a mutual collaboration with Shalom Hospice as referring partners once they are granted licensure. I look forward to the Health Facilities Commission approving Shalom Hospice so that we may work with Shalom Hospice when that time comes."*

Savannah Burkhart, General Manager, Home Instead

> *"… Shalom Hospice's service intensity is unique and not currently available in our region. It will be of particular interest to our home care clients and their families. … Given our home care footprint and patients we are referred and/or admit, I would expect there to be mutual collaboration with Shalom Hospice including referral of appropriate patients on a regular basis…."*

The above quoted facilities represent only a portion of those facilities which provided letters of support. Demonstrating substantial market need as expressed by the region's assisted living facilities, 44 percent of Hamilton County's 18 assisted living facilities have provided letters of support with some quantifying their referrals. 100 percent of Marion County's assisted living facilities as there is only one – supports Shalom Hospice. Bradley County has 7 assisted living facilities; one has provided its support Shalom Hospice as of this date. Of note, there are no assisted living facilities in Polk or Sequatchie Counties. In aggregate, 10 of the 26 Service Area assisted living facilities, or 38 percent, have already voiced support for Shalom Hospice.

With respect to nursing homes, there are 17 in the five-county service area. Three have provided support at this early stage, which includes one-third of the Bradley nursing homes and 18 percent of Hamilton County providing support for Shalom Hospice. In aggregate, these facilities represent 18 percent of the Service Area facilities to date.

In addition to the above facility-based providers who were able to shed light on the quantification of patients they would refer to Shalom Hospice, Rabbi Perlstein, Chabad of Chattanooga, indicates a substantial number of referrals. Bill Tobin, Preferred Care at Home indicates mutual collaboration and referring partners without quantifying the monthly referrals as did Savannah Burkhart with Home Instead. In addition, Sarah Aronson who is both a 911 ambulance provider and a member of the Jewish Burial Society, other rabbis and other organized Jewish leadership in the Service Area have conveyed their support for Shalom Hospice and the qualitative need for a Jewish hospice agency. Additionally, local physicians with Jewish patients have also conveyed their support for Shalom Hospice and its emphasis on serving persons of the Jewish faith. These latter groups are mostly based in Hamilton County but have constituents, congregants and/or patients from throughout the Service Area. These letters of support were presented in response to **Question 1N-2** above and are included in **Attachment 1N-2**.

Given the quantified patient referrals from these supporters and the incremental qualitative referral discussions herein, the Applicant's has projected the annual number of patients to be admitted during the first two years of operation to be 79 in year one and 156 in year two. This is further detailed in response to **Questions 2N and 6N**.

To fulfill the demand for a hospice agency that places an emphasis on serving the Jewish population, the Applicant will establish specific protocols for meeting the special needs through a series of initiatives described below. Shalom Hospice is Jewish owned and operated thus by its very nature, it is in tune with the cultural sensitivities and religious beliefs required to serve this special population.

Documentation of Shalom Hospice's plan to address the special needs of the service area population is provided in response to **Question 4N** in the main application form. In sum, the plan includes the following initiatives:

- Shalom Hospice will become the first NIJH Accredited hospice agency in Southeast Tennessee to achieve this recognition.

- Shalom Hospice will ascribe to Chayim Aruchim.

- Shalom Hospice will employ Jewish Rabbi to serve as its chaplain, one that will incorporate Jewish ritual, faith, laws and customs and encourage the patient to reflect on their life, pass on wisdom, and make amends.

- The social worker(s) to serve on Shalom Hospice's team will understand and have knowledge of the Jewish Resources that are available during the end of life.

- All Shalom Hospice nurses will be educated on NIJH accreditation, and Jewish programs, rituals and traditions.

- All Shalom Hospice patient care personnel, in addition to the nurses, will be educated on NIJH accreditation, and Jewish programs, rituals and traditions.

- Shalom Hospice will work with the Chabad Jewish Center, Jewish Cultural Center, Jewish Federation, Jewish Burial Sociates and with local rabbis to sponsor quarterly community education events and workshops at Jewish community centers and congregations regarding the benefits of hospice services, including an explanation of the hospice benefit available under Medicare, the interdisciplinary team approach to care for patients in hospice, and the ways in which hospice can meet the physical, emotional, and spiritual needs of Jewish patient and the patient's family at the end of life.

- Shalom Hospice's plan is to have a Jewish services coordinator on its staff available to respond to needs of Jewish patients, and to be available to respond to any requests from each referring agencies including referring Jewish Cultural Center, Chabad Jewish Center, physicians, nursing homes, assisted living facilities and any other Jewish community organization for assistance and evaluation of patients, including but not limited to 24/7 triage coverage, physical visits to assess hospice eligibility of patients and admission regardless of ability to pay (charity patients); and availability of palliative care programs for Jewish patients that are in need of support but do not presently meet the requirements for admission to hospice care.

- Shalom Hospice will develop a bereavement program specifically designed to address the needs of the Jewish patients, families, caregivers and those who are in need of grief support regardless if they are associated with hospice services.

- Shalom Hospice will implement the Rendever Virtual Reality platform for the Jewish population that honors the history and plight of the Jewish experience and provides "travel" to religiously significant sites and experiences throughout the world.

- Implementation of Shalom Hospice will satisfy the Consumer Advantage criteria by enabling the Jewish community to enroll in hospice services designed specifically for their end of life needs while incorporating specialty programs not available in Southeast Tennessee. Further, given that the program is a Medicare benefit, the program will have no impact on these consumers costs.

Given the need as delineated above, and Shalom Hospice's plan to serve the Jewish population in addition to ensuring it will provide hospice services to all patients who are clinically appropriate for end of life care, regardless of their ability to pay, the Applicant satisfies the intent of this criterion. Importantly, the Applicant will provide significant Consumer Advantage in terms of Choice, Improved Accessibility and Availability.

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 five-county Service Area. None of the existing 9 licensed agencies throughout the Service Area places an emphasis on serving the terminally ill Jewish residents of Bradley, Hamilton, Marion, Polk and Sequatchie Counties. No other agency is accredited by NIJH; and none follows Chayim Aruchim. Therefore, Shalom Hospice will have no adverse impact on any of the existing hospice agencies licensed to serve its defined Service Area. And more importantly, Shalom Hospice will offer a service that does not currently exist thereby becoming a distinct Consumer Advantage in terms of choice, availability and accessibility.

LETTER OF INTENT

State of Tennessee
Health Facilities Commission

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

www.tn.gov/hsda Phone: 615-741-2364 hsda.staff@tn.gov

LETTER OF INTENT

The Publication of Intent is to be published in The Chattanooga Times Free Press which is a newspaper of general circulation in Bradley, Hamilton, Marion, Polk and Sequatchie Counties, Tennessee, on or before 06/14/2024 for one day.

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 Shalom Hospice of Southeast Tennessee LLC, a/an Hospice Agency owned by Shalom Hospice of Southeast Tennessee LLC with an ownership type of Limited Liability Company and to be managed by itself intends to file an application for a Certificate of Need for Shalom Hospice of Southeast Tennessee LLC, a newly formed hospice agency with an ownership type of limited liability company, which is jointly owned by Samuel Stern and the SYGS 2023 Trust, and will be self-managed, 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 Hamilton, Marion, Sequatchie, Bradley and Polk Counties. While the hospice agency will not discriminate against members of any religion (or any other protected class), the hospice agency will have a specific emphasis on serving persons of the Jewish faith.. The address of the project will be 1200 Premier Drive, Suite 210, Chattanooga, Hamilton County, Tennessee, 37421. The estimated project cost will be $500,000.

The anticipated date of filing the application is 07/01/2024

The contact person for this project is Attorney Michael Brent who may be reached at Bradley Arant Boult Cummings, LLP - 1221 Broadway, Suite 2400, Nashville, Tennessee 37203 – Contact No. 615-252-2361.

Michael Brent	06/14/2024	mbrent@bradley.com
Signature of Contact	**Date**	**Contact's Email Address**

The Letter of Intent must be received between the first and the fifteenth day of the month. If the last day for filing is a Saturday, Sunday, or State Holiday, filing must occur on the next business day. Applicants seeking simultaneous review must publish between the sixteenth day and the last day of the month of publication by the original applicant.

The published Letter of Intent must contain the following statement pursuant to T.C.A. §68-11-1607 (c)(1). (A) Any healthcare 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 may file a 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. Written notice of opposition may be sent to: Health Facilities Commission, Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243 or email at hsda.staff@tn.gov .

State of Tennessee
Health Facilities Commission

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

www.tn.gov/hsda Phone: 615-741-2364 hsda.staff@tn.gov

PUBLICATION OF INTENT

The following shall be published in the "Legal Notices" section of the newspaper in a space no smaller than two (2) columns by two (2) inches.

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 Shalom Hospice of Southeast Tennessee LLC, a/an Hospice Agency owned by Shalom Hospice of Southeast Tennessee LLC with an ownership type of Limited Liability Company and to be managed by itself intends to file an application for a Certificate of Need for Shalom Hospice of Southeast Tennessee LLC, a newly formed hospice agency with an ownership type of limited liability company, which is jointly owned by Samuel Stern and the SYGS 2023 Trust, and will be self-managed, 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 Hamilton, Marion, Sequatchie, Bradley and Polk Counties. While the hospice agency will not discriminate against members of any religion (or any other protected class), the hospice agency will have a specific emphasis on serving persons of the Jewish faith.. The address of the project will be 1200 Premier Drive, Suite 210, Chattanooga, Hamilton County, Tennessee, 37421. The estimated project cost will be $500,000.

The anticipated date of filing the application is 07/01/2024

The contact person for this project is Attorney Michael Brent who may be reached at Bradley Arant Boult Cummings, LLP - 1221 Broadway, Suite 2400, Nashville, Tennessee 37203 – Contact No. 615-252-2361.

The published Letter of Intent must contain the following statement pursuant to T.C.A. §68-11-1607 (c)(1). (A) Any healthcare 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 may file a 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. Written notice of opposition may be sent to: Health Facilities Commission, Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243 or email at hsda.staff@tn.gov .

ORIGINAL APPLICATION

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

CERTIFICATE OF NEED APPLICATION

1A. Name of Facility, Agency, or Institution

Shalom Hospice of Southeast Tennessee LLC
Name

1200 Premier Drive, Suite 210 | Hamilton County
Street or Route | **County**

Chattanooga | Tennessee | 37421
City | **State** | **Zip**

www.shalomtn.com
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

Patti Greenberg | Consultant
Name | **Title**

National Healthcare Associates | pgreenberg@nhaconsulting.com
Company Name | **Email Address**

999 PONCE DE LEON BLVD
Street or Route

Coral Gables | Florida | 33134-3047
City | **State** | **Zip**

Consultant | 305-444-5007
Association with Owner | **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: 06/14/24

Date LOI was Published: 06/14/24

RESPONSE: See attachment 3A

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

- [x] Establish New Health Care Institution
- [ ] Relocation
- [ ] Change in Bed Complement
- [ ] Addition of a Specialty to an Ambulatory Surgical Treatment Center (ASTC)
- [ ] Initiation of MRI Service
- [ ] MRI Unit Increase
- [ ] Satellite Emergency Department
- [ ] Addition of Therapeutic Catheterization
- [ ] Positron Emission Tomography (PET) Service
- [x] Initiation of Health Care Service as Defined in §TCA 68-11-1607(3)

Initiation of HealthCare services

- [ ] Burn Unit
- [ ] Neonatal Intensive Care Unit
- [ ] Open Heart Surgery
- [ ] Organ Transplantation
- [ ] Cardiac Catheterization
- [ ] Linear Accelerator
- [ ] Home Health
- [x] Hospice
- [ ] Opiate Addiction Treatment Provided through a Non-Residential Substitution-Based Treatment Section for Opiate Addiction

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
- [ ] 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

Other -

Hospital -

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

Sam Stern and SYGS 2023 Trust

Name

135 Lakeview Drive | 510-499-9977

Street or Route | **Phone Number**

Lawrenceville | New York | 11559

City | **State** | **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
- ☑ 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: Shalom Hospice of Southeast Tennessee LLC. is a newly formed Limited Liability Corporation formed for purpose of establishing in-home hospice services in Tennessee. Shalom Hospice of Southeast Tennessee LLC is owned by Samuel Stern (5%) and the SYGS 2023 Trust (95%). The Applicant will be self-managed. Attachment 7A includes the Applicant's organizational chart, corporate charter, certificate of corporate existence and documentation from the State of Tennessee's website denoting the corporation's active status. Mr. Stern also has The Stern Family Trust which is the owner of Shalom Hospice LLC along with Mr. Stern. The SYGS 2023 Trust was established to separate the hospice agencies into more than one trust for estate planning and valuation purposes. It is similarly governed so from an operational standpoint the two trusts have common leadership, mission and vision as does the applicant entity.

8A. Name of Management/Operating Entity *(If 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.
- ☑ 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.
- ☐ Letter of Intent, or other document showing a commitment to lease the property - attach reference document
- ☐ Other (Specify)

RESPONSE: The fully executed lease and the quit claim deed evidencing the lessor's ownership of the property are included as Attachment 9A.

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 approximately 2,425 square feet will serve as an administrative office for operation of Shalom Hospice of Southeast Tennessee. 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 is Suite 210, 1200 Premier Drive, Chattanooga, TN 37421 in Hamilton County. 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 enabling staff to be located throughout the Service Area without need to regularly frequent the office. Notwithstanding that patients do not go to Shalom Hospice's office, Chattanooga Area Regional Transit Authority (CARTA) has one bus route (Route 4) that travels Route 11/Brainerd Road and passes by E. Brainerd Road, which may be used to access Premier Drive. The intersection of E. Brainerd Road and Brainerd Road is approximately 1.5 miles from the office location. A copy of this bus route 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.

(Attachment 12A)

RESPONSE: The project is an in-home hospice agency, 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 (Provide signed USPS green-certified mail receipt card for each official notified.)
  - ☐ Notification in process, attached at a later date
  - ☐ Notification not in process, contact HFC Staff
  - ☑ 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 (Provide signed USPS green-certified mail receipt card for each official notified.)
  - ☐ Notification in process, attached at a later date
  - ☐ Notification not in process, contact HFC Staff
  - ☐ 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.

  RESPONSE:

  Shalom Hospice of Southeast Tennessee LLC ("Shalom Hospice" or "Applicant"), 1200 Premier Drive, Suite 210, Chattanooga, Hamilton County, Tennessee, is a limited liability company, and newly formed entity for the purposes of establishing a new healthcare service of in-home hospice in the state of Tennessee. Shalom Hospice will place an emphasis on serving terminally-ill individuals of the Jewish faith in Hamilton, Bradley, Marion, Polk and Sequatchie Counties in a manner that recognizes and honors Jewish heritage, history, rituals and traditions. This hospice will be licensed separately from the other Shalom Hospice affiliates in Tennessee.

- Ownership structure

  RESPONSE: Shalom Hospice of Southeast Tennessee LLC is owned by Samuel Stern (5%) and the SYGS 2023 Trust (95%). Shalom Hospice will be self-managed. Mr. Stern and one of his trusts operate Shalom Hospice LLC in Middle Tennessee and Shalom Hospice of Greater Knoxville in east Tennessee. It also operates in other states under the name Affinity Care or Continuum Care. Collectively, the organization operates 27 affiliate hospice offices across 12 states and the District of Columbia, including Tennessee, Georgia, Florida, Washington, New Jersey, Virginia, Ohio, Indiana, Missouri, Maine, Oklahoma, Pennsylvania and Washington, D.C. All Shalom Hospice, Affinity Care and Continuum Care entities are affiliated to one another through common ownership, leadership, mission, values and common quality goals. Throughout this application, the affiliate entities operating as either Affinity Care or Continuum Care, are referred to collectively as "Affinity Care" or "Affinity Health".

- Service Area

  RESPONSE: Shalom Hospice's administrative offices will be in leased office space within Chattanooga (Hamilton County) geographically proximate to the various Jewish organizations in the region to facilitate regular interaction. Its service area is defined as Hamilton, Bradley, Marion, Polk and Sequatchie Counties. It is these five counties that are home to the 3,000 to 4,000 Jewish people residing in southeast Tennessee.

- Existing similar service providers

  RESPONSE: There are currently no hospice providers in the defined service area that place an emphasis on serving the Jewish community. However, there are 9 licensed in-home hospice agencies serving one or more Service Area county. By county, licensed agencies range between 7 and 9 of the 9 total. Combined, there were 5,451 hospice admissions in the Service Area in 2023. The Applicant will fill a void in service through its programming thereby enhancing accessibility and availability of Jewish hospice services for the Jewish terminally-ill throughout the Service Area.

- Project Cost

  RESPONSE: The Applicant will lease 2,425 SF at 1200 Premier Drive, Suite 201 in Chattanooga, Tennessee. The initial term of the lease is for 63 months. The actual lease with security deposit totals approximately $287,000 over this period; the assessed value times the percent occupied totals $238,000 (fair market value of the space). The Project Cost Chart reflects $287,000 because the lease cost exceeds the fair market value of the space. Total costs are $500,000 including the lease.

- Staffing

RESPONSE: The Applicant will employ 12.5 Full-Time Equivalents (FTEs) in Year 1 of which 9.3 will be direct patient care staff. This includes 1 clinical director, 2 RN (ratio of 1:10) including a part time floater, 1.8 aides (ratio of 1:8), 1 social worker (ratio of 1:25), 1 chaplain (to be an ordained rabbi, a ratio of 1:25), ½ an FTE for music therapy (a ratio of 1:50), 1 bereavement coordinator and 1 on-call nurse (ratio of 1:50). Shalom Hospice's staffing ratios exceed NHPCO Guidelines. In addition to the direct patient care positions, Shalom Hospice will employ 3 non-patient care FTEs in Year 1. Shalom Hospice will have a medical director via contract services. The Applicant will be able to appropriately staff these personnel and provide services for which CON approval is being sought.

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

  RESPONSE: Under Jewish rituals, the returning of one's soul to God at the end of its journey in this world is the most profound moment in a person's life. As the soul approaches eternal life in heaven, religion becomes a source of comfort and peace. Because the existing hospice agencies are not familiar with Jewish rituals and customs, they are unable to ease the spiritual anguish of the dying and their families. The Applicant will fill a void in service thereby enhancing accessibility and availability of Jewish hospice services for the Jewish terminally ill throughout the Service Area. All the uniquely tailored Jewish initiatives the Applicant will provide are described throughout this application. While Shalom Hospice will place an emphasize on serving the Jewish population, it will not deny any hospice eligible patient who elects Shalom Hospice for end of life care.

- Quality Standards

  RESPONSE: Shalom Hospice will become CHAP Accredited and it will become the first hospice agency in Southeast Tennessee to become accredited by the National Institute for Jewish Hospice (NIJH). There are several characteristics of Affinity Health hospice agencies that distinguish it from the other hospice agencies. But most significant, Affinity Health prides itself on its service intensity, which far surpasses NHPCO guidelines for staffing. If awarded this CON, Shalom Hospice will introduce a level of service that extends beyond what is currently available in this market. Further, Shalom Hospice will implement its Music Therapy Program whereby it employs a board certified music therapist that visits all patients who welcome it. It will also offer its unique Virtual Reality and Equine Therapy Programs. More information on the quality programs and services to be provided by Shalom Hospice is presented herein.

- Consumer Advantage

  - Choice

    RESPONSE: Because there is no existing Jewish hospice agency in Southeast Tennessee or the Greater Chattanooga area, and specifically none that follow Chayim Aruchim and/or are NIJH Accredited, Jewish terminally ill residents currently have no choice but to utilize non-Jewish hospice agencies. While these agencies provide core hospice services, they do not necessarily recognize or have the knowledge of Jewish rituals and customs, particularly as it relates to death and dying. Shalom Hospice will offer a choice to these residents who are of the Jewish faith and wish to have a Jewish hospice option.

  - Improved access/availability to health care service(s)

    RESPONSE: Shalom Hospice will raise the bar in terms of service intensity and turnaround time/responsiveness in the Service Area. First, every new patient will be engaged within two hours of referral, seven days a week. The two-hour turnaround time is a testament to Shalom Hospice's dedication to serving the needs of hospice appropriate patients. Most hospice organizations will tell a caller on a Saturday that someone will be out to see the patient on Monday. Shalom Hospice will initiate the admission process with that patient within two hours. Next, Shalom Hospice will assure each patient has 5 to 7 Home Health Aide visits per week, provided this is acceptable to the IDT, patient and family. Third, the Applicant will assure each patient has a minimum of 2 RN visits per week, provided this is acceptable to the IDT, patient and family. The Applicant also commits to increasing visit frequency during the final weeks of life to provide support. The Applicant will utilize Muse Healthcare Analytics to assist in identifying patients who are entering their final days of life. Each of these metrics exceeds the standard

of hospice care and, collectively, will improve access and availability to hospice services benefiting consumers in the Service Area.

- Affordability

RESPONSE: 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. The 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 treat any hospice eligible patient in the Service Area without regard to the person's ability to pay.

3E. Consent Calendar Justification

- ☐ Letter to Executive Director Requesting Consent Calendar (Attach Rationale that includes addressing the 3 criteria)
- ☑ Consent Calender NOT Requested

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.

4E. PROJECT COST CHART

A. Construction and equipment acquired by purchase:	
1. Architectural and Engineering Fees	
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$75,000
3. Acquisition of Site	
4. Preparation of Site	
5. Total Construction Costs	
6. Contingency Fund	$60,000
7. Fixed Equipment (Not included in Construction Contract)	
8. Moveable Equipment (List all equipment over $50,000 as separate attachments)	$75,000
9. Other (Specify): _____	
B. Acquisition by gift, donation, or lease:	
1. Facility (inclusive of building and land)	
2. Building only	$287,000
3. Land only	
4. Equipment (Specify): _____	
5. Other (Specify): _____	
C. Financing Costs and Fees:	
1. Interim Financing	
2. Underwriting Costs	
3. Reserve for One Year's Debt Service	
4. Other (Specify): _____	
D. Estimated Project Cost (A+B+C)	$497,000
E. CON Filing Fee	$3,000
F. Total Estimated Project Cost (D+E) **TOTAL**	$500,000

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 reasonable ness. 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:

See attached 2N PDF response.

Complete the following utilization tables for each county in the service area, if applicable.

PROJECTED UTILIZATION

Unit Type: ☐ Procedures ☐ Cases ☑ Patients ☐ Other _____

Service Area Counties	Projected Utilization Recent Year 1 (Year = 2025)	% of Total
Marion	6	7.59%
Bradley	16	20.25%
Hamilton	49	62.03%
Sequatchie	4	5.06%
Polk	4	5.06%
Total	79	100%

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

RESPONSE:

See attached 3N PDF response.

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).

RESPONSE:

See attached 3N PDF response.

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:

See attached 4N PDF response.

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:

See attached 5N PDF response.

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:

See attached 6N PDF response.

7N. Complete the chart below 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 the applicant, and the percentage of ownership that is shared with the applicant's owners.

RESPONSE:

Neither Shalom Hospice of Southeast Tennessee LLC, nor any of its affiliates, have any outstanding CONs for hospice or any other regulated service in the State of Tennessee. The Shalom Hospice for Middle Tennessee which was awarded its CON in Q2 2022 was expeditiously licensed and Medicare certified. It is now meeting the needs of the Jewish population in Middle Tennessee. Similarly, Shalom Hospice of Greater Knoxville which was awarded its CON in Q3 2023 was expeditiously licensed and Medicare certified. It began meeting the needs of the Jewish population in Greater Knoxville in April 2024 upon its Medicare certification.

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: Shalom 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. 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 hospice services contract for general inpatient and respite care with a skilled nursing facility is supplied in Attachment 1C.

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

- [x] Aetna Health Insurance Company
- [x] Ambetter of Tennessee Ambetter
- [x] Blue Cross Blue Shield of Tennessee
- [x] Blue Cross Blue Shield of Tennessee Network S
- [x] Blue Cross Blue Shiled of Tennessee Network P
- [x] BlueAdvantage
- [x] Bright HealthCare
- [x] Cigna PPO
- [x] Cigna Local Plus
- [ ] Cigna HMO - Nashville Network
- [x] Cigna HMO - Tennessee Select
- [ ] Cigna HMO - Nashville HMO
- [x] Cigna HMO - Tennessee POS
- [x] Cigna HMO - Tennessee Network
- [ ] Golden Rule Insurance Company
- [ ] HealthSpring Life and Health Insurance Company, Inc.
- [x] Humana Health Plan, Inc.
- [x] Humana Insurance Company

- ☐ John Hancock Life & Health Insurance Company
- ☐ Omaha Health Insurance Company
- ☐ Omaha Supplemental Insurance Company
- ☐ State Farm Health Insurance Company
- ☑ United Healthcare UHC
- ☑ UnitedHealthcare Community Plan East Tennessee
- ☐ UnitedHealthcare Community Plan Middle Tennessee
- ☐ UnitedHealthcare Community Plan West Tennessee
- ☑ WellCare Health Insurance of Tennessee, Inc.
- ☑ Others

RESPONSE: The majority of Shalom Hospice's patients will be Medicare and TennCare. While its affiliates have contracts in its other hospices with managed care organizations, it is Affinity's 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. However, it should be noted, Affinity Care in each of its hospices reaches out to all Medicaid managed care organizations and other managed care providers to become credentialed and execute a contractual arrangement to serve any enrollees of those entities. Shalom Hospice will do the same with all entities identified in its Service Area. Of note, Shalom Hospice in Middle Tennessee received its Medicare certification in February 2023 and its Medicaid provider number approximately 90 days later. Both were in place as of May 2023 enabling contracting with the Medicaid entities to occur starting May 2023. Shalom Hospice of Greater Knoxville received its Medicare certification effective April 2024. However, it is still waiting on its receipt of its Medicare provider number. Once received, it will apply to Tennessee to become Medicaid certified and obtain its Medicaid provider number.

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:

See attached 3C, 4C and 5C PDF response.

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:

See attached 3C, 4C and 5C PDF response.

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:

See attached 3C, 4C and 5C PDF response.

PROJECTED DATA CHART

☑ Project Only
☐ Total Facility

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

	Year 1	Year 2
	2025	2026
A. Utilization Data		
Specify Unit of Measure Other : Patient Days	3379	10235
B. Revenue from Services to Patients		
1. Inpatient Services	$0.00	$0.00
2. Outpatient Services	$658,265.00	$2,023,796.00
3. Emergency Services	$0.00	$0.00
4. Other Operating Revenue (Specify) _____	$0.00	$0.00
Gross Operating Revenue	$658,265.00	$2,023,796.00
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$13,165.00	$40,476.00
2. Provision for Charity Care	$38,609.00	$60,714.00
3. Provisions for Bad Debt	$3,291.00	$10,119.00
Total Deductions	$55,065.00	$111,309.00
NET OPERATING REVENUE	$603,200.00	$1,912,487.00

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.

Project Only Chart

	Previous Year to Most Recent Year	Most Recent Year	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	$0.00	$0.00	$194.81	$197.73	0.00
Deduction from Revenue *(Total Deductions/Utilization Data)*	$0.00	$0.00	$16.30	$10.88	0.00
Average Net Charge *(Net Operating Revenue/Utilization Data)*	$0.00	$0.00	$178.51	$186.86	0.00

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 percentage of Medicare. The Applicant's Medicare charges are based on Medicare reimbursement and estimated to be $183.40 for routine care based on a blend of the two routine payment amounts. Inpatient care is estimated to be $1043.31 per day. Respite care is set at $464.58 per day which is the Medicare rate and continuous care is set at $58.17 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 $179 per patient day for the first year of operation and $187 per patient day in the second year of operation.

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 2023 charges of area providers and the corresponding fiscal 2025 charges for the Applicant.

Rates by Hospice Agency within the Service Area Counties Fiscal Year 2023					
State ID	**Hospice Agency**	**Routine**	**Continuous**	**Inpatient**	**Respite**
06063/06613	Adoration Home Health and Hospice Care East TN	$203	$1,463	$1,068	$474
06603	Kindred Hospice	$183	$1,293	$970	$432
19694	Avalon Hospice	$193	$1,368	$1,016	$452
33603	Amedisys Hospice an Adventa Company	$153	$500	$825	$409
33643	Avalon Hospice	$190	$1,343	$1,001	$445
33653	Caris Healthcare	$190	$1,343	$1,001	$445
33673	Hearth Hospice of Tennessee	$158	$1,251	$996	$434
33613	Hospice of Chattanooga Inc	$158	$1,396	$990	$445
47602	Amedisys Hospice an Adventa Company	$139	$500	$909	$383
	Average, Licensed Hospice Agencies	**$174**	**$1,162**	**$975**	**$435**
	Average, Licensed Hospice Agencies in Service Area	**$176**	**$1,227**	**$979**	**$441**
	Shalom Hospice of Southeast Tennessee 12/24-11/25)	**$156-$198**	**$58/hour**	**$1,043**	**$465**

Source: Joint Annual Reports by Provider, Page 6, FY 2023. The range in routine is for the 1-60 day and 60+ day routine payments; the resulting average is based on mix of patients. State ID 33643 - Gentiva Hospice replaced Avalon Hospice in the table in the 2023 JAR.

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 have a slightly higher average routine charges per day than the 9 licensed providers. Additionally, continuous care is paid on an hourly basis. The approximate $1,300 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, Shalom Hospice's Year 1 (2024-2025) is on par with the Service Area provider's average net revenue per patient day. Specifically, in 2023 the routine rate of $174 overall, or $176 for the Service Area hospices, inflated by three years to the forecasted time frame, results in $185 to $187 per day for routine days. Shalom Hospice's routine rate ranges between $156 and $198 with an average of $183.40 before pre-Medicare write offs and $178.51 including those write offs. This is consistent with the Service Area routine rates at the existing providers. Given routine represents 98 percent of Shalom Hospice forecasts, when factoring in inpatient, respite and continuous days, its average only increases by $1 to $2 per day. Accordingly, Shalom Hospice's forecast 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 without regard to the person's ability to pay.

10C. 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.

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

Applicant's Projected Payor Mix

Project Only Chart

Payor Source	Year-2025		Year-2026	
	Gross Operating Revenue	**% of Total**	**Gross Operating Revenue**	**% of Total**
Medicare/Medicare Managed Care	$585,388.00	88.93	$1,799,739.00	88.93
TennCare/Medicaid	$54,658.00	8.30	$168,043.00	8.30
Commercial/Other Managed Care	$12,146.00	1.85	$37,343.00	1.85
Self-Pay	$6,073.00	0.92	$18,671.00	0.92
Other(Specify)				
Total	$658,265.00	100%	$2,023,796.00	100%
Charity Care	$38,609.00		$60,714.00	

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

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.

RESPONSE: The proposed hospice agency's projected payor mix for the first two years of operation was derived based on its evaluation of the Service Area, its experience and its anticipated referrals from area nursing homes, congregations and other Jewish organizations. The majority (89 percent) of patient days are generated from Medicare recipients. Another 8 percent are derived from TennCare/Medicaid while 2 percent will be Commercial/Managed Care. It is projected that $60,714 in charity care (3 percent) will be provided during the second year of operation. The Shalom Hospice (Middle Tennessee) indigent care policy is supplied as an Attachment. Shalom Hospice of Southeast Tennessee will adopt an identical policy.

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.

- [x] Yes
- [ ] No

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?

  - [x] Yes
  - [ ] No

- Does the applicant commit to obtaining and maintaining all applicable state licenses in good 3tanding?

  - [x] Yes
  - [ ] No

- Does the applicant commit to obtaining and maintaining TennCare and Medicare certification(s), if participation in such programs are indicated in the application?

  - [x] Yes
  - [ ] No

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.

Credential	Agency	Status (Active or Will Apply)	Provider Number or Certification Type
Licensure	☑ Health Facilities Commission/Licensure Division ☐ Intellectual & Developmental Disabilities ☐ Mental Health & Substance Abuse Services	Will Apply	
Certification	☑ Medicare ☑ TennCare/Medicaid ☑ Other NIJH	Will Apply Will Apply Will Apply	
Accreditation(s)	CHAP – Community Health Accreditation Partner	Will Apply	

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

- ☑ AMERIGROUP COMMUNITY CARE- East Tennessee
- ☐ AMERIGROUP COMMUNITY CARE - Middle Tennessee
- ☐ AMERIGROUP COMMUNITY CARE - West Tennessee
- ☑ BLUECARE - East Tennessee
- ☐ BLUECARE - Middle Tennessee
- ☐ BLUECARE - West Tennessee
- ☑ UnitedHealthcare Community Plan - East Tennessee
- ☐ UnitedHealthcare Community Plan - Middle Tennessee
- ☐ UnitedHealthcare Community Plan - West Tennessee
- ☑ TENNCARE SELECT HIGH - All
- ☑ TENNCARE SELECT LOW - All
- ☐ PACE
- ☐ KBB under DIDD waiver
- ☐ Others

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?

- ☑ 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.

  - ☐ Yes
  - ☐ No
  - ☑

☐ N/A

- 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.)

  ☐ Yes
  ☐ No
  ☑ N/A

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;

  ☐ Yes
  ☑ No

- Criminal fines in cases involving a Federal or State health care offense;

  ☐ Yes
  ☑ No

- Civil monetary penalties in cases involving a Federal or State health care offense;

  ☐ Yes
  ☑ No

- Administrative monetary penalties in cases involving a Federal or State health care offense;

  ☐ Yes
  ☑ No

- 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;

  ☐ Yes
  ☑ No

- Suspension or termination of participation in Medicare or TennCare/Medicaid programs; and/or

  ☐ Yes
  ☑ No

- Is presently subject of/to an investigation, or party in any regulatory or criminal action of which you are aware.

  ☐ Yes
  ☑ No

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.

☐ Existing FTE not applicable (Enter year)

Position Classification	Existing FTEs(enter year)	Projected FTEs Year 1
A. Direct Patient Care Positions		
Clinical Director	0.00	1.00
RN	0.00	2.00
Aide	0.00	1.80
Social Worker	0.00	1.00
Chaplain	0.00	1.00
Music Therapist	0.00	0.50
Bereavement Coordinator	0.00	1.00
On Call RN	0.00	1.00
Total Direct Patient Care Positions	N/A	9.3
B. Non-Patient Care Positions		
Administrator	0.00	1.00
Hospice Liaison	0.00	1.00
Office Assistant	0.00	1.00
Total Non-Patient Care Positions	N/A	3
Total Employees *(A+B)*	0	12.3
C. Contractual Staff		
Contractual Staff Position	0.00	0.20
Total Staff *(A+B+C)*	0	12.5

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 Commission, 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		08/28/24
2. Building Construction Commenced	0	08/27/24
3. Construction 100% Complete (Approval for Occupancy)	0	08/27/24
4. Issuance of License	80	11/15/24
5. Issuance of Service	96	12/01/24
6. Final Project Report Form Submitted (Form HR0055)	186	03/01/25

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

1N -- 2

Assisted Living Facilities for Future Community Linkage Plan

1. Eagle Crest Assisted Living, Chattanooga
2. Morning Pointe of Chattanooga at Shallowford
3. Davis Home for the Aged III
4. NHC Healthcare, Chattanooga
5. The Terrace Mountain Creek
6. Rose of Sharon's Senior Villa
7. Friendship Haven
8. Lockhart Community Care Home
9. Morning Pointe of Hixson
10. Southern Heritage Assisted Living
11. Life Care Center of Collegedale
12. The Bridge at Ooltewah
13. Garden Plaza of Cleveland (Bradley)
14. Life Care Center of Copper Basin (Polk)
15. NHC Healthcare, Sequatchie

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FaithBasedAssistedLiving.org
(https://www.faithbasedassistedliving.org/)

Jewish Assisted Living in Hamilton County, Tennessee

There are 12 Jewish assisted living facilities in Hamilton County, Tennessee. These Jewish senior living communities in Hamilton County provide care to seniors in a Jewish environment in all 12 facilities.

ROSE OF SHARON'S SENIOR VILLA

Rose Of Sharon's Senior Villa provides Jewish assisted living care in Chattanooga, Tennessee. The senior living facility can accommodate a maximum of 28 residents at a time. With a location at 5410 Lee Avenue, in the 37410 area code inside Hamilton county, Rose Of Sharon's Senior Villa provides assisted living services and enables Jewish seniors to keep their culture and traditions alive. Rose Of Sharon's Senior Villa offers help with daily tasks such as assistance with taking a bath, personal grooming and individual care plans. Residents enjoy Jewish faith based religious services and amenities that include Kosher kitchen. Jewish holidays are observed at this assisted living residence.

(877) 311-8349 ⓘ Learn More View Pricing & Availability

LOCKHART COMMUNITY CARE HOME

Lockhart Community Care Home offers assisted living in Hamilton county, Tennessee. Up to 6 65+adults can take advantage of its services and choose from numerous assisted apartment layouts. Lockhart Community Care Home offers Jewish seniors to continue living a full spiritual life in addition to helping with daily activities when needed. Lockhart Community Care Home can provide aid with cooking, bathing, dressing and incontinence care to senior citizens in Chattanooga, TN and surrounding areas. Lockhart Community Care Home is located at 704 Rockway Dr. , 37411 and specializes in caring for seniors with dementia.

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EAGLE CREST ASSISTED LIVING

Jewish seniors who are looking for assisted living facility in Chattanooga, Tennessee, may consider Eagle Crest Assisted Living. This assisted living facility is an excellent luxurious senior care option. This Jewish home has a total of 16 assisted living units and includes services such as spiritual care, housekeeping,

toileting, grooming, walking trails and staff available 24/7. Its license number is 318. Eagle Crest Assisted Living provides senior living to all Hamilton county seniors as well.

(877) 369-9195 ⓘ (877) 369-9195 ⓘ Learn More View Pricing & Availability

NHC HEALTHCARE, CHATTANOOGA

Retirees who need help with daily living may want to explore Nhc Healthcare, Chattanooga. This assisted living facility can help you or your loved one to find the assistance and personal care you need in Chattanooga, Tennessee. Nhc Healthcare, Chattanooga has a maximum capacity of 200 seniors who want to find an assisted living that follows Jewish traditions and includes amenities such as transportation services, help with managing medication, apartment cleaning, help with cooking, Kosher dining and more. Older adults can enjoy an apartment plan of their choice at Nhc Healthcare, Chattanooga.

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LIFE CARE CENTER OF COLLEGEDALE

Life Care Center Of Collegedale can accommodate 124 retirees who are looking for an assisted living center that follows Jewish traditions and offers services such as monthly doctor visits, on-site nurse, regular health checkups and help with medication management. This Jewish retirement home is located at 9210 Apison Pike, and it is fully equipped to provide assisted living to Collegedale, TN residents.

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MORNING POINTE OF HIXSON

Located at 5501 Old Hixson Pike, inside 37343 zip code area in Hamilton county, Morning Pointe Of Hixson provides assisted senior living to Hixson, TN seniors and includes services such as scheduled transportation, medication management, linen services, help with housekeeping, help with meal preparation and more. Morning Pointe Of Hixson can house up to 78 older adults at a time and provides multiple amenities and services to Hixson residents.

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THE BRIDGE AT OOLTEWAH

Located at 5901 Snow Hill Road, Ooltewah, Tennessee, 37363, The Bridge At Ooltewah can help any Hamilton county resident who requires senior living assistance and includes services such as scheduled transportation, help with meal preparation, Internet, help with laundry and more. The Bridge At Ooltewah can provide assisted living services to no more than 108 Ooltewah residents at once. The Bridge At Ooltewah is licensed by Tennessee with license number 381.

(877) 369-9195 ⓘ Jewish Assisted Living in Hamilton County, TN Learn More View Pricing & Availability

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SOUTHERN HERITAGE ASSISTED LIVING I

Retirees looking for Jewish senior living residences in East Ridge, Tennessee will find Southern Heritage Assisted Living I, that is located at 5310 Clemons Road inside 37412 zip code as a great choice for all of their personal needs. Southern Heritage Assisted Living I offers access to a local Rabbi and enables residents to continue practicing the Jewish faith, so Hamilton county seniors can continue visiting their local synagogue while getting all the senior care services they need, such as medication management, round-the-clock caregiving, help with bathing and moving around and more. Southern Heritage Assisted Living I is able to care for up to 32 older adults. Tennessee records indicate 331 license number for Southern Heritage Assisted Living I.

(877) 659-8659 ⓘ Learn More View Pricing & Availability

MORNING POINTE OF CHATTANOOGA AT SHALLOWFORD

Morning Pointe Of Chattanooga At Shallowford is located at 7719 Shallowford Road in Hamilton county, and serves as an assisted living facility in Chattanooga, TN. Seniors who live in surrounding areas can receive assisted living care. This senior living facility includes amenities such as medication set-up and reminders, a wellness center and emergency pendants. This Jewish retirement community can house up to 84 Chattanooga older adults. Morning Pointe Of Chattanooga At Shallowford has an official license to provide senior living accommodations for Hamilton, TN senior residents with license # 400.

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FRIENDSHIP HAVEN

Older adults who require assisted living in Chattanooga, Tennessee can take advantage of Friendship Haven, situated at 950 Dodson Avenue. Friendship Haven offers amenities such as help with housekeeping, on-site hair salons and grooming, medication management, daily fitness activities and Kosher dining. Seniors can continue following the Jewish faith at this facility and there is an easy access to a local synagogue available. Friendship Haven is capable of caring for up to 16 senior citizens from 37406 zip code in Hamilton county and nearby areas. Friendship Haven has an active license to offer assisted living in Chattanooga, Tennessee License number: 603.

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THE TERRACE AT MOUNTAIN CREEK

Jewish Assisted Living in Hamilton County, TN

The Terrace At Mountain Creek provides Jewish assisted living care in Chattanooga, Tennessee. The senior living facility can accommodate a maximum of 120 residents at a time. With a location at 1005 Mountain Creek Road, in the 37405 area code inside Hamilton county, The Terrace At Mountain Creek provides assisted living services and enables Jewish seniors to keep their culture and traditions alive. The Terrace At Mountain Creek offers help with daily tasks such as assistance with taking a bath, personal grooming and individual care plans. Residents enjoy Jewish faith based religious services and amenities that include Kosher kitchen. Jewish holidays are observed at this assisted living community.

(877) 659-8659 ⓘ

(877) 369-9195 ⓘ Learn More View Pricing & Availability

DAVIS HOME FOR THE AGED III

Davis Home For The Aged Iii offers assisted living in Hamilton county, Tennessee. Up to 27 senior residents can take advantage of its services and choose from numerous assisted apartment layouts. Davis Home For The Aged Iii offers Jewish seniors to continue living a full spiritual life in addition to helping with daily activities when needed. Davis Home For The Aged Iii can provide aid with cooking, bathing, dressing and incontinence care to senior citizens in Chattanooga, TN and surrounding areas. Davis Home For The Aged Iii is located at 1106 Duncan Ave. , 37404 and helps seniors with dementia.

(877) 659-8659 ⓘ Learn More View Pricing & Availability

Other faith based assisted living options in Oneida Hamilton County, TN:

Christian assisted living in Hamilton County, TN
(https://www.faithbasedassistedliving.org/christian/tennessee/hamilton-county.html)

Catholic assisted living in Hamilton County, TN
(https://www.faithbasedassistedliving.org/catholic/tennessee/hamilton-county.html)

See other Jewish assisted living facilities near you:

Jewish Assisted Living in Shelby County, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/shelby-county.html)

Jewish Assisted Living in Davidson County, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/davidson-county.html)

Jewish Assisted Living in Knox County, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/knox-county.html)

Jewish Assisted Living in Sumner County, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/sumner-county.html)

Jewish Assisted Living in Hawkins County, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/hawkins-county.html)

Jewish Assisted Living in Williamson County, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/williamson-county.html)

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Jewish Senior Living (https://www.faithbasedassistedliving.org/jewish/) /
Tennessee (https://www.faithbasedassistedliving.org/jewish/tennessee/) / Jewish Assisted Living in Bradley County

Jewish Assisted Living in Bradley County, Tennessee

There are 1 Jewish assisted living facilities in Bradley County, Tennessee. These Jewish senior living communities in Bradley County provide care to seniors in a Jewish environment in all 1 facilities.

GARDEN PLAZA OF CLEVELAND

Garden Plaza Of Cleveland provides Jewish assisted living care in Cleveland, Tennessee. The senior living facility can accommodate a maximum of 49 residents at a time. With a location at 3500 Keith Street, in the 37312 area code inside Bradley county, Garden Plaza Of Cleveland provides assisted living services and enables Jewish seniors to keep their culture and traditions alive. Garden Plaza Of Cleveland offers help with daily tasks such as assistance with taking a bath, personal grooming and individual care plans. Residents enjoy Jewish faith based religious services and amenities that include Kosher kitchen. Jewish holidays are observed at this assisted living residence.

(877) 311-8349 Learn More View Pricing & Availability

Other faith based assisted living options in Oneida Bradley County, TN:

Christian assisted living in Bradley County, TN
(https://www.faithbasedassistedliving.org/christian/tennessee/bradley-county.html)

Catholic assisted living in Bradley County, TN
(https://www.faithbasedassistedliving.org/catholic/tennessee/bradley-county.html)

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Jewish Assisted Living in Davidson County, TN (https://www.faithbasedassistedliving.org/jewish/tennessee/davidson-county.html)

Jewish Assisted Living in Knox County, TN (https://www.faithbasedassistedliving.org/jewish/tennessee/knox-county.html)

Jewish Assisted Living in Hamilton County, TN (https://www.faithbasedassistedliving.org/jewish/tennessee/hamilton-county.html)

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Jewish Assisted Living in Polk County, Tennessee

There are 1 Jewish assisted living facilities in Polk County, Tennessee. These Jewish senior living communities in Polk County provide care to seniors in a Jewish environment in all 1 facilities.

LIFE CARE CENTER OF COPPER BASIN

Life Care Center Of Copper Basin provides Jewish assisted living care in Ducktown, Tennessee. The senior living facility can accommodate a maximum of 135 residents at a time. With a location at 166 Copper Basin Industrial Park, in the 37326 area code inside Polk county, Life Care Center Of Copper Basin provides assisted living services and enables Jewish seniors to keep their culture and traditions alive. Life Care Center Of Copper Basin offers help with daily tasks such as assistance with taking a bath, personal grooming and individual care plans. Residents enjoy Jewish faith based religious services and amenities that include Kosher kitchen. Jewish holidays are observed at this assisted living community.

(877) 311-8349 ⓘ **Learn More** **View Pricing & Availability**

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Jewish Assisted Living in Knox County, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/knox-county.html)

Jewish Assisted Living in Hamilton County, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/hamilton-county.html)

Jewish Assisted Living in Sumner County, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/sumner-county.html)

Jewish Assisted Living in Hawkins County, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/hawkins-county.html)

Jewish Assisted Living in Williamson County, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/williamson-county.html)

Jewish Assisted Living in Wilson County, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/wilson-county.html)

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Jewish Assisted Living in Dunlap, Tennessee

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NHC HEALTHCARE, SEQUATCHIE

Nhc Healthcare, Sequatchie provides care to seniors in a Jewish environment. This Jewish senior living home is located in Dunlap, Tennessee. The senior living facility offers accommodation to a maximum of 110 senior residents at a time. With a location at 360 Dell Trail, in the 37327 area code inside Sequatchie county, Nhc Healthcare, Sequatchie provides assistance and support to 65+ adults who want to continue celebrating Jewish traditions after moving to an assisted living community. Nhc Healthcare, Sequatchie includes assisted living services such as cooking and serving meals, medication management and help with taking a bath, getting dressed, laundry and assisting with toilet. Shabbat services are also included.

(877) 311-8349 ⓘ **Learn More** **View Pricing & Availability**

More jewish assisted living facilities near Dunlap, TN

Jewish Assisted Living in Lebanon, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/[illegible])

Jewish Assisted Living in Ducktown, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/duck

Jewish Assisted Living in Farragut, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/farragut.html)

Jewish Assisted Living in Tullahoma, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/tulla

Jewish Assisted Living in Bells, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/[illegible])

Jewish Assisted Living in Bartlett, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/bart

Jewish Assisted Living in Rutledge, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/[illegible])

Jewish Assisted Living in Hendersonville, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/hend

Jewish Assisted Living in Oak Ridge, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/oak

Jewish Assisted Living in Spring City, TN
(https://www.faithbasedassistedliving.org/jewish/tennessee/sprir

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Charity Care Policy, Sample

SHALOM HOSPICE

CHARITY CARE	Effective: 3/1/2019
Fiscal Management	Policy No.: 5009

PURPOSE

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

POLICY

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

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

The organization will consistently apply the charity care policy.

PROCEDURE

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

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

The Executive Director/Administrator, with the appropriate program director, will review all applicable patient information, including financial declarations, physician (or other authorized licensed independent practitioner) orders, initial assessment information, and social work notes to determine acceptance for charity care.

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

When financial declarations reveal the patient is able to make partial payment for services, the Executive Director/Administrator, with the appropriate program director, will determine the sliding-fee schedule to be implemented.

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

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

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

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

CHARITY CARE	Policy Number:
CHAP Standards: CIII.3a	
Federal Regulatory Citation: 418.100(e)	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 3/1/2019	

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Leadership Resources

Leadership Resources

Shalom Hospice has a leadership team with a wealth of experience in the startup of new hospice programs nationally. The organization is led by Samuel Stern, Affinity Care and Shalom Hospice's Founder and Chief Executive Officer who first founded Continuum Care Hospice in 2013 and opened its first program in 2015. The states in which the affiliates hospices are licensed include Washington, Tennessee, Florida, Pennsylvania, Virginia, Ohio, Missouri, Indiana, Maine, Oklahoma and Connecticut as well as the District of Columbia. All these Affinity Care programs have common ownership, service intense features, same mission, vision and values and the same integrity and common goal to provide hospice for all, including minority populations who historically have lesser access and utilization of hospice care.

Shalom Hospice, with its seasoned leadership team and ability to successfully recruit top-notch hospice staff, is well positioned to develop a hospice program with an emphasis on serving the Jewish community in Southeast Tennessee. At the end of 2022, it successfully licensed Shalom Hospice in Middle Tennessee. That entity had a deficiency free licensure survey. Subsequently, February 2023 it had a deficiency free CHAP accreditation survey subsequent to which it received its Medicare provider number. Less than 90 days after its CHAP accreditation survey, it also received its TennCare provider number.

At the end of 2023, it successfully licensed Shalom Hospice of Greater Knoxville in East Tennessee. That entity had a deficiency free licensure survey. Subsequently, April 2024 it had a deficiency free CHAP accreditation survey. It is still awaiting its Medicare provider number; upon receipt it will apply for Medicaid certification.

A brief bio on the executive leadership team is presented below.

Samuel Stern, MBA, Founder and Chief Executive Officer

Samuel Stern is founder and CEO of Affinity Health. Since 2013, Mr. Stern has provided executive leadership leading to the growth of Continuum Care and Affinity Health through nine states. Continuum was a pioneer with Medi-Cal Managed Care to provide Palliative services under California SB1004 and arrangements with multiple health system. He has demonstrated his commitment to respecting choices and providing quality of care to patients near the end of life. Mr. Stern has many years of executive leadership during which he founded and was the CEO of multiple state CHAP Accredited and Medicare Certified Hospice agencies. Part of his success is driven out of providing end of life care to underserved populations by developing relationships within communities focused on improving access to care.

Mr. Stern holds a Master of Business Administration degree from the University of Michigan's Ross School of Business

Jason Lancaster, Chief Operating Officer

Jason Lancaster serves as the Chief Operations Officer for Affinity having joined the company in 2023. Jason is the direct report for the Executive Directors throughout the United States. With nearly two decades within the Hospice industry, Jason has operated as an Executive Director in 8 states and Puerto Rico. Jason has worked in National leadership positions for over a decade with responsibilities and support in more than 20 states.

Previously Jason worked as a consultant and Chief Marketing Officer for Pera Holding Companies in Fruitland, Idaho. Pera's objective is to partner with and manage under resourced hospice programs to produce growth and better patient outcomes through a "strength in numbers" approach.

From 2014 to 2022, Jason served as the Vice President of Operations at Ascend Hospice & Palliative Care in Cranford New Jersey. Beginning as an Executive Director in Kansas City, Jason was quickly promoted through the organization to oversee all programs and operations nationally (CA/MA/KS/MO/PA/VA/NJ/ PR).

Ariel Aric Joudai, CPA, Chief Financial Officer

Ariel Aric Joudai, CPA joined the team in 2016 as the organization's Chief Financial Officer. He has more than 13 years of experience in Financial Accounting and Auditing and has contributed to Continuum's growth nationally.

Mr. Joudai holds a BS in Accounting from Binghamton University of New York and is a Certified Public Accountant. He began his career as a financial auditor for KPMG, LLP; Assistant Controller for Marx Development; then Junior Controller for Maverick Management Corporation.

Shirley Mackey, RN, CHPN, National Clinical Director and Director of Quality and Compliance

Shirley Mackey serves as the National Clinical Director and Director of Quality and Compliance to all of the Affinity Health affiliated hospices. In this role, Mrs. Mackey oversees all QAPI initiatives, HIS reporting, clinical education, and corporate compliance with regulatory agencies. Prior to joining the organization, Mrs. Mackey was the Clinical Director of Kindred Hospice, Director of Clinical Services at AseraCare and served as a Quality Director for Genesis HealthCare. She holds RN licenses in Washington, California, Pennsylvania, New York and a Compact License in Texas (to cover all compact states including Florida, New Jersey and Virginia).

Thomas J. Cristinati, Jr., RN, Regional Clinical Educator

Thomas J Cristinati, Jr. serves as Affinity Health's Regional Clinical Educator and supports all of the Continuum Care and Affinity Care affiliated hospice offices. In this capacity he assesses learning needs through direct observation, formal needs assessment, and program evaluation or other organizational activity reports. He is responsible for creating educational programs and materials based on assessments of specific populations to be educated. Mr. Cristinati is an experienced Registered Nurse who was also a Licensed Funeral Director for more than fifteen years.

Prior to joining the organization, Mr. Cristinati served as the Director of Operations at Amedisys. Prior to his work with hospice organizations, Mr. Cristinati was a critical care nurse at an acute care hospital. Mr. Cristinati holds a Bachelor of Science Degree in Nursing from the University of Hartford.

Alison Lanman, RN, After Hours Triage Manager

Alison Lanman, RN, serves as Affinity Health's After Hours Triage Manager. In this capacity Mrs. Lanman has hired, trained, and managed a team of remote hospice triage nurses to provide triage services for multistate hospice offices. As triage manager, she is interfaced with leadership in multiple offices to meet state requirements and the needs of each office. Triage services include making recommendations for palliative care, consulting with physicians, managing orders, teaching patients and families regarding disease process and palliative measures, coordinating care with hospitals, nursing facilities, physicians, and pharmacies. The remote triage nurse supports and dispatches field nurses for direct patient care.

Mrs. Lanman has a long history in the hospice industry. Prior to joining Continuum, she worked with Amedisys. She holds a Bachelor of Science Degree in Nursing from University of Southern Maine.

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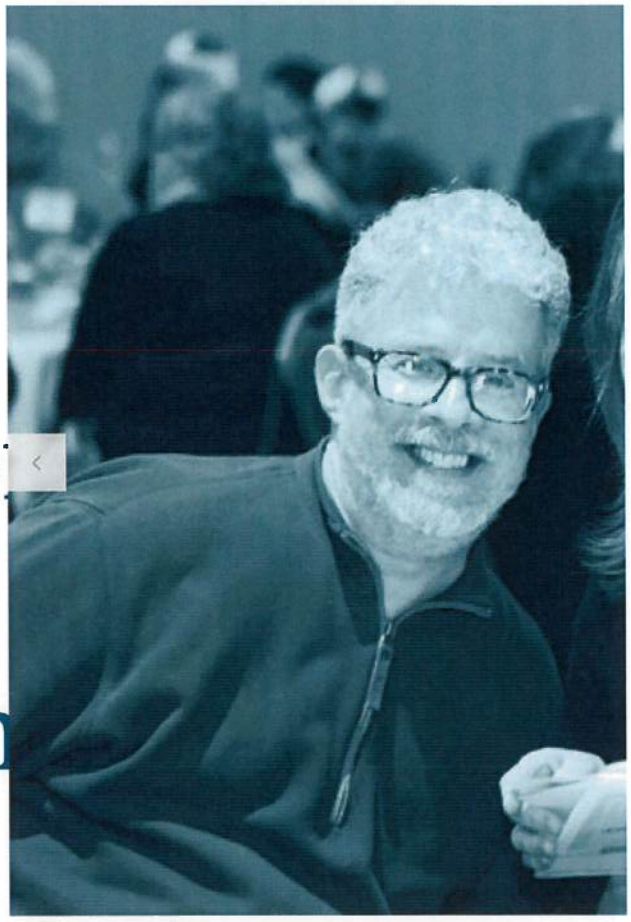
National Institute for Jewish Hospice Information

The National Institute for Jewish Hospice

What can NIJH Accreditation do for your organization



When you train your staff with knowledge of Jewish culture, values and traditions, you will create greater satisfaction from your Jewish clients and their families. The NIJH Accreditation will generate client comfort and referrals, resulting in growth of your business. *(more...)*

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November 18 – 19, 2021

Participation in our annual conference is one of the requirements for National Institute of Jewish Hospice Accreditation and Re-Accreditation.

NIJH Accreditation & Re-Accreditation

Build your reputation in the Jewish Community

Through the NIJH training, your staff will gain enhanced understanding of Jewish culture and religion, and their impact on death and dying. They will integrate understanding of Jewish medical ethics into hospice care, and they will discover unique aspects of Jewish grief and mourning.

The annual NIJH Conference

Participation by your hospice at our annual NIJH Conference is

NIJH Jewish Holiday Information

Before every Jewish holiday, you will receive an

of life caring from a Jewish perspective, Jewish aspects of Consolation and Bereavement, caring for different groups within Judaism and other important topics. Attendees participate in dynamic lectures and sessions, and network with hospice professionals ...ss the U.S.

Find an Accredited Hospice

...ining

NIJH Accreditation includes annual training of your staff that interacts with the patient and/or the patient's family (nurses, social workers, chaplains, aides, etc.) with the NIJH Training Program. We provide a Training Outline and PowerPoint program of 90 slides covering all aspects of Jewish Heritage & Holidays, Jewish Medical Ethics and The Final Journey — Death, Burial and Mourning. Through the NIJH training, your staff will gain enhanced understanding of Jewish culture and religion, and their impact on death and dying. They will integrate hospice concerns. Distributing this information to all your staff enhances their knowledge of Jewish culture, religion and history.

Access to All NIJH Materials (coming soon)

As a NIJH Accredited hospice, you will have free access to all of our material on our website. You will be able to download articles, pamphlets, audio lectures and The NIJH Living Will with Durable Power of Attorney, "Vidui"- The Final Prayer card, and "Guidelines" (what to do at death, preparing the body and the funeral), for use in your hospice.

Listing on our Website

As a NIJH Accredited Hospice, your hospice will be listed on our website, enabling people to find your hospice and your contact information easily.

Media and Marketing Kit

You will also be provided with the NIJH Accredited Hospice

and mourning.

Jewish community. This will enable your organization to build a network of Jewish connections of rabbis, temples, organizations, etc.

"As a Christian working in a Jewish hospice, I was not aware of many customs. It was imperative of me to learn and understand the customs to be able to provide holistic care. Thank you!"

National Institute For Jewish Hospice
732 University Street
North Woodmere, New York 11581

Email: shirlamm@nijh.org

24 hour toll-free number
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For Patients & Families

Hospice means the patient comes first.

Their specially trained staff can make sure the patient is as comfortable as possible at all times. The hospice staff becomes an extension of the family, easing everyone's pain and burden. Professional support that is both compassionate and culturally sensitive is invaluable for patients and their families. *(Learn more...)*

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hospice near you.

Hospices who are NIJH accredited have been trained in the unique issues and challenges of serving the Jewish terminally ill.

Find an NIJH Accredited Hospice

NIJH contributes to how Jewish patients and their families are treated during end of life transitions.

We train the staff of hospices to be sensitive to Jewish concerns. On this page you'll find information (booklets) on many important end of life issues. We also maintain a 24-hour hotline to provide advice to both families and caregivers.

Rabbi Dr. Maurice Lamm was the founder of The National Institute for Jewish Hospice. For several decades Jews have turned to Rabbi Maurice Lamm's classic work, The Jewish Way in Death and Mourning, for direction and consolation. Selected by The New York Times as one of the ten best religious books of the year when it was first

tradition provide guidelines that have helped people manage this end-of-life period of crisis through attitudes, rituals, prayers and religious symbols that most Jews observe at least in part.

as many practices
ms that are very meaningful, especially to a dying patient. These might be holiday celebrations, prayers, kosher dietary laws, charity etc. Generally, hospice services take place in the home. (There are a few in hospitals.) When a hospice worker comes into the home, if he/she is familiar with these practices and customs it makes the hospice experience significantly easier on the patient and the family.

There are many different groups within Judaism, from secular all the way to Ultra-Orthodox. Within those groupings there are many commonalities and many

difficult chapter of life- from the moment of death through the funeral service, the burial, and the various periods of mourning.

We've made many of the topics covered in *The Jewish Way on Death and Mourning* available here, free for download.

Rabbi Lamm gently leads through the corridors of Jewish law and teaches the aching heart how to express its pain in love and respect so that it might begin on the road to eventual healing.

1) For Families of the Jewish Terminally Ill

2) The Eternal Jewish Beliefs

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NIJH teaches the traditional Jewish viewpoint, highlighting the major differences. We stress that these are generalities and the hospice has to learn what are the particulars of each client.

6) Jewish Medical Ethics and End of Life Care

7) Realities of the Dying

7) Singing Breaks the Spiritual Deadlock

8) Implementing Empathy at the End of Life

10) Jewish Mourning Customs – An Overview

11) Comforting the Bereaved

12) Death is a Night Between Two Days

13) Consolation; Shiva, The Habitat of Healing

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A 24-hour toll-free number counsels families, patients and care-givers, and provides locations of hospices, hospitals, health professionals and clergy of all faiths.

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The National Institute for Jewish Hospice

Guidance

NIJH enhances a hospice's ability to respond to the diverse needs of Jewish patients and their families in a caring, dignified manner, consistent with Jewish heritage and values.

Guidance

NIJH enhances a hospice's ability to respond to the diverse needs of Jewish patients and their families in a caring, dignified manner, consistent with Jewish heritage and values.

What is The National Institute for Jewish Hospice?

The Institute For Jewish Hospice (NIJH) was established in 1985 by Rabbi Dr. Maurice Lamm to help alleviate suffering in serious and terminal illness. Since it's founding, NIJH has accredited hundreds of hospices and trained thousands of hospice professionals across the country. Its more than 52,000 members are comprised of business and professional leaders, and a consortium of endowing foundations. NIJH serves as an essential resource and educational center for hospices, hospitals, family service, medical organizations and all health-care agencies,

educating them to the unique issues and challenges of serving the Jewish terminally ill.

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and all health-care agencies, educating them to the unique issues and challenges of serving the Jewish terminally ill.

For Patients & their Families

The needs of the patient must always come first. In the past 36 years, we have made a significant difference in the treatment of the Jewish terminally ill.

Find an NIJH Accredited Hospice near you.

Get free downloads to help your family through this profound journey.

For Providers & Accreditation

The ongoing education and resources provided through NIJH accreditation helps your organization be recognized for your support and understanding of the unique and diverse end of life needs of the Jewish community.

Register for the NIJH Virtual Conference: November 18 & 19, 2021.

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Videos Highlighting Specialty Programming

Affinity Care Videos

Please take a moment to view clips and a PBS segment on our Virtual Reality, Music Therapy and Equine Therapy programs:

https://youtu.be/dAlPcRxI1CM

https://www.cnet.com/videos/bucket-lists-get-checked-off-in-vr/

https://affinityhealthmanagement.com/what-is-equine-therapy/

https://affinityhealthmanagement.com/what-is-virtual-reality/

https://affinityhealthmanagement.com/what-is-music-therapy/

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Music Therapy Program and Policy & Procedure

CONTINUUM	MUSIC THERAPY SERVICES	Effective: 9/1/2019
	Patient Services	Policy No.:

PURPOSE

To ensure that appropriate music therapy services are provided to hospice patients and families/caregivers according to American Music Therapy Association Standards of Clinical Practice.

POLICY

Continuum will provide music therapy services by credentialed music therapists (i.e., MT-BC, RMT, CMT) under the direction of a physician and in accordance with the plan of care. Duties and responsibilities of music therapists will be identified in appropriate job descriptions.

Music Therapy services will include:

1. Assessing factors that will help determine a patient and family/caregiver's response to music, music skills and musical preferences.
2. Interventions aimed at improving a patient and family/caregiver's quality of life; promoting healing and growth; and/or maintaining functional levels as appropriate. Specific interventions may include, but are not limited to:
   a. singing
   b. songwriting
   c. lyric discussion
   d. moving to music
3. Establishing goals and evaluating progress toward goals

Music therapy services are discussed at the start of care and referrals may be made by the admission nurse, RN Case Manager, SW or Physician. Services may also be discussed at any interdisciplinary group meeting. A music therapist is assigned to a patient and family/caregiver based on the patient's and family's needs and acceptance of these services. Once referred for assessment, the music therapist will participate in the development, implementation and revision of the plan of care.

RI Specific: Music Therapy services shall be directed by and shall be provided under the supervision of a music therapist registered by the Rhode Island Department of Health.

PROCEDURE

1. The music therapist will contribute to the comprehensive assessment and ongoing updates to the comprehensive assessment based on the needs of the patient. Assessment activities of the music therapist will include but not be limited to:

   A. the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client's needs and strengths. The assessment will also determine the client's responses to music, music skills and musical preferences; and

   B. exploration of the client's culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity or expression, and social organizations.

   C. current diagnosis and history will be performed in a manner congruent with the client's level of functioning to address the following areas:

      1. motor skills

      2. reality orientation

      3. emotional status

      4. spatial and body concepts

      5. long- and short-term memory

      6. attending behaviors

      7. infection control precautions

      8. Sensory acuity and perception

      9. Independent functioning and adaptive needs

      10. coping skills

   D. All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing, if appropriate for the patient's condition or other circumstances. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

2. Music therapy assessments and interventions will be documented in the patient's clinical record as part of the comprehensive assessment and in interdisciplinary visit notes, as well as the plan of care. Documentation will include:

   A. Goals of care

B. Observations of the needs or problems of the patient and family/caregiver, as identified in assessments

C. Interventions provided to address the needs or problems of the patient and family/caregiver and the patient's and/or family/caregiver's response and progress towards goals

D. Plans and/or referrals made to address the needs or problems of the patient and family/caregiver in accordance with the plan of care

3. All music therapy services will be performed at the patient's place of residence as appropriate

4. Music Therapy personnel will participate in hospice inservice programs to maintain and improve their specialized skills.

5. Music Therapy personnel will participate in IDG meetings and quality assessment performance improvement teams, as indicated.

MUSIC SERVICES	Policy Number:
CHAP Standard(s):	
Federal Regulatory Citation:	
State/Local Regulatory Citation: 216-RICR-40-05-26	
Dates Reviewed/Revised: 9/1/2019	

American Music Therapy Association

8455 Colesville Rd., Ste. 1000 • Silver Spring, Maryland 20910
Tel. (301) 589-3300 • Fax (301) 589-5175 • www.musictherapy.org

MUSIC THERAPY AND MUSIC-BASED INTERVENTIONS IN THE TREATMENT AND MANAGEMENT OF PAIN: SELECTED REFERENCES AND KEY FINDINGS

What is Music Therapy?

Music Therapy is a discipline whose professionals make use of clinical and evidence-based music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapy is an established health profession that uses music and the therapeutic relationship to address physical, psychological, cognitive and/or social functioning for patients of all ages and disabilities. Because music therapy is a powerful and physically non-invasive medium, unique outcomes are possible when interventions are directed to reduce pain, anxiety, and depression. These outcomes appear to be mediated through the individual's emotional, cognitive and interpersonal responsiveness to the music and/or the supportive music therapy relationship.

A review of the extensive published literature on this topic reveals several lines of research, largely among three major disciplines: music therapists, nurses, and physicians. Many of these studies were conducted independently by the various disciplines; however, collaborative research among Board Certified Music Therapists with other professional disciplines (particularly nursing) is on the rise.

When music is employed as an ambient and adjunct modality or tool during procedures, in the perioperative environment, and/or for use in chronic pain management, there exists considerable diversity in the literature with respect to the music listening protocol. In many cases, the authors of the published literature do not specify the exact protocol and/or why certain music was used. This is a limitation of a portion of the literature; however, it is important to understand that many of the findings from these studies can help shape, inform, and refine future research by Board Certified Music Therapists, other professionals, and in collaborative research environments.

Finally, it is important to note that the Board Certified Music Therapist employs a wide variety of music therapy interventions based on a) the best available evidence from the published literature, b) the therapist's training, expertise and specializations, and c) the client's needs and preferences. Programming and selection of individualized music and sound stimuli is only a small piece of the Board Certified Music Therapist's practice. A diverse array of underlying theories forms the foundation for music therapy interventions. Examples include frameworks from behavioral, psychodynamic, psychological, and neurobiological theories. For the topic of pain and pain management, emerging findings from neuroscience with applied music therapy interventions are trending towards a fuller understanding of why certain music therapy interventions influence outcomes more favorably than others.

OVERVIEW OF SELECTED RESEARCH

Systematic Reviews, Meta-Analyses and Literature Reviews

Standley, J.M. (2000). Music research in medical treatment. In D. Smith (Ed.) *Effectiveness of Music Therapy Procedures: Documentation of Research and Clinical Practice*. American Music Therapy Association: Silver Spring, MD.

Standley, J.M. (1992). Meta analysis of research in music and medical treatment. Effect size as a basis for comparisons across multiple dependent and independent variables. In R. Spintge and R. Droh (Eds). *Music Medicine*, St Louis: MMB.

Music Therapy reduces pain perception.

Fratianne, R.B, Presner, J.D., Houston, M.J., Super, D.M., Yowler, C.J.& Standley, J.M. (2001). The effect of music – based imagery and musical alternate engagement on the burn debridement process. *Journal of Burn Care & Rehabilitation. 22*(1): 47-53

Good, M., Anderson, G.C., Stanton-Hicks, M., Grass, J.A. & Makil, M. (2002). Relaxation and music reduce pain after gynecologic surgery. *Pain Management Nursing, 3* (2): 61-70.

Son, J.T. & Kim, SH. (2006). The effects of self-selected music on anxiety and pain during burn dressing changes. *Taehan Kanho Hakhoe Chi.* 36(1):159-68.

Tan, X., Yowler, C.J., Super, D.M. & Fratianne, R.B. (2010). The efficacy of music therapy protocols for decreasing pain, anxiety, and muscle tension levels during burn dressing changes: a prospective randomized crossover trial. *J Burn Care Res.*, 31(4):590-7.

Music Therapy reduces physiological indicators of anxiety and reduces need for sedation and analgesia, increases completion rate, and shortens examination time during colonoscopy.

Smolon, D., Topp, R. & Singer, L. (2002). The effect of self-selected music during colonoscopy on anxiety, heart, rate, and blood pressure. *Applied Nursing Research. 15* (3): 126-36.

Schiemann, U., Gross, M., Reuter, R. & Kellner, H. (2002). Improved procedure of colonoscopy under accompanying music therapy. *European Journal of Medical Research. 7* (3): 131-4.

Music Therapy reduces cortisol in healthy adults.

McKinney, C.H., Antoni, M.H., Kumar, M., Tims, F.C. & McCabe, P.M. (1997). Effects of Guided Imagery and Music (GIM) Therapy on mood and cortisol in healthy adults. *Health Psychology 16* (4). 390–400.

Music Therapy reduces physiological and psychological indicators of distress in perioperative patients. Perioperative music therapy changes the neurohormonal and immune stress response to day surgery, especially when music selection considered patient preference. While clinically important, outcome effect size and significance levels vary across studies.

Allred, K.D., Byers, J.F. & Sole, M.L. (2010). The effect of music on postoperative pain and anxiety. *Pain Manag Nurs.* 11(1):15-25.

Cadigan, M.E., Caruso, N.A., Halderman, S.M., McNamara, M.E., Noyes, D.A., Spadafora, M.A. & Carrol, D.L. (2001). The effect of music on cardiac patients on bed rest. *Progress in Cardiovascular Nursing. 16* (1): 5-13.

Dabu-Bondoc, S., Vadivelu, N., Benson, J., Perret, D. & Kain, Z.N. (2009). Hemispheric synchronized sounds and perioperative analgesic requirements. *Anesth Analg.* 110(1):208-10. Epub 2009 Oct 27.

Engwall, M. & Duppils, G.S. (2009). Music as a nursing intervention for postoperative pain: a systematic review. *J Perianesth Nurs.* 24(6):370-83.

Good, M., Albert, J.M., Anderson, G.C., Wotman, S., Cong, X., Lane, D. & Ahn, S. (2010). Supplementing relaxation and music for pain after surgery. *Nurs Res.* 59(4):259-69.

Good, M., Anderson, G.C., Ahn, S., Cong, X. & Stanton-Hicks, M. (2005). Relaxation and music reduce pain following intestinal surgery. *Res Nurs Health.* 28(3):240-51.

Leardi, S., Pietroletti, R., Angeloni, G., Necozione, S., Ranalletta, G. & Del Gusto, B. (2007). Randomized clinical trial examining the effect of music therapy in stress response to day surgery. *Br J Surg.* 94(8):943-7.

Miluk-Kolasa, B., Matejek, M. & Stupnicki R. (1996). The effects of music listening on changes in selected physiological parameters in adult pre-surgical patients. *Journal of Music Therapy, 33*, 208–218.

Nilsson, U., Lindell, L., Eriksson, A. & Kellerth, T. (2009). The effect of music intervention in relation to gender during coronary angiographic procedures: a randomized clinical trial. *Eur J Cardiovasc Nurs.*;8(3):200-6.

Nilsson, U. (2009). Soothing music can increase oxytocin levels during bed rest after open-heart surgery: a randomised control trial. *J Clin Nurs.* 18(15):2153-61.

Nilsson, U. (2008). The anxiety- and pain-reducing effects of music interventions: a systematic review. *AORN J.* 87(4):780-807.

Nilsson, U., Unosson, M. & Rawal, N. (2005). Stress reduction and analgesia in patients exposed to calming music postoperatively: a randomized controlled trial. *Eur J Anaesthesiol.* 22(2):96-102.

Robb, S.L., Nichols R.J., Rutan R.L. & Bishop B.L. (1995). The effects of music assisted relaxation on preoperative anxiety. *Journal of Music Therapy, 32*, 2–21.

Simcock, X.C., Yoon, R.S., Chalmers, P., Geller, J.A., Kiernan, H.A. & Macaulay, W. (2008). Intraoperative music reduces perceived pain after total knee arthroplasty: a blinded, prospective, randomized, placebo-controlled clinical trial. *J Knee Surg.* 21(4):275-8.

Szmuk, P., Aroyo, N., Ezri, T., Muzikant, G., Weisenberg, M. & Sessler, D.I. (2008). Listening to music during anesthesia does not reduce the sevoflurane concentration needed to maintain a constant bispectral index. *Anesth Analg.* 107(1):77-80.

Walworth, D., Rumana, C.S., Nguyen, J. & Jarred, J. (2008). Effects of live music therapy sessions on quality of life indicators, medications administered and hospital length of stay for patients undergoing elective surgical procedures for brain. *J Music Ther.* 45(3):349-59.

Engaging in group music therapy and listening to music reduces anxiety associated with chemotherapy and radiotherapy. Listening to music reduces nausea and emesis for patients receiving chemotherapy.

Cai, G., Qiao, Y., Li, P., & Lu, L. (2001). Music therapy in treatment of cancer patients. *Chinese Mental Health Journal, 15*(3), 179-181.

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How Does Music Therapy Make a Difference?

Music therapy has been shown to be an efficacious and valid treatment option for patients experiencing pain related to a variety of diagnoses. Music therapy interventions can focus on pain management for physical rehabilitation, cardiac conditions, medical and surgical procedures, obstetrics, oncology treatment, and burn debridement, among others. Music is a form of sensory stimulation, which provokes responses due to the familiarity, predictability, and feelings of security associated with it. Research results and clinical experiences attest to the viability of music therapy even in those patients resistant to other treatment approaches.

What Do Music Therapists Do?

Music therapy utilized in the treatment and management of pain complies with the expectations and requirements inherent in the medical model of treatment. Music therapy programs are based on individual assessment and collection of extensive data for the development of complex patient histories and client-centered treatment plans. Patient objectives are specific and relevant to medical diagnosis, course of treatment, and discharge timeline.

Once goals and objectives are established, music therapists use music activities, both instrumental and vocal, designed to facilitate changes that are non-musical in nature. Through a planned and systematic use of music and music strategies, the music therapist provides opportunities for:

- Anxiety and stress reduction
- Nonpharmacological management of pain and discomfort
- Positive changes in mood and emotional states
- Active and positive patient participation in treatment
- Decreased length of stay

Functioning as members of an interdisciplinary team, music therapists also evaluate the patients during the course of treatment, implement changes that are indicated by the patient's response, and document benefits in medical, not musical, terms.

How Does Music Therapy Help Patients?

Music therapy can help to relieve pain and reduce stress and anxiety for the patient, resulting in physiological changes, including:

- Improved respiration
- Lower blood pressure
- Improved cardiac output
- Reduced heart rate
- Relaxed muscle tension

Music therapy has been shown to have a significant effect on a patient's perceived effectiveness of treatment, self-reports of pain reduction, relaxation, respiration rate, behaviorally observed and self-reported anxiety levels, and patient choice of anesthesia and amount of analgesic medication.

Music Therapy Protocol for Pain Management

"[This protocol]... is based on a cognitive behavioral model of therapy, which posits that new thoughts, feelings and body states may be conditioned to replace dysfunctional patterns. Specifically, a relaxed body and pleasant visual images may replace tension and worry when they are conditioned as a response to familiar, calming music. The conditioning process takes place when listening to this music is paired with deep relaxation through repeated practice. Over time, the music alone cues the response...

The music therapy protocol is designed to perform several functions:

To direct attention away from pain or anxiety, distracting the listener with comforting music.
To provide a musical stimulus for rhythmic breathing.
To offer a rhythmic structure for systematic release of body tension.
To cue positive visual imagery.
To condition a deep relaxation response.
To change mood.
To focus on positive thoughts and feelings and to celebrate life."

- Professor Suzanne Hanser, EdD, MT-BC, Berklee College of Music

Who is Qualified as a Music Therapist?

Graduates of colleges or universities from more than 70 approved music therapy programs are eligible to take a national examination administered by the Certification Board for Music Therapists (CBMT), an independent, non-profit certifying agency fully accredited by the National Commission for Certifying Agencies. After successful completion of the CBMT examination, graduates are issued the credential necessary for professional practice, Music Therapist-Board Certified (MT-BC). In addition to the MT-BC credential, other recognized professional designations are Registered Music Therapists (RMT), Certified Music Therapists (CMT), and Advanced Certified Music Therapist (ACMT) listed with the National Music Therapy Registry. Any individual who does not have proper training and credentials is not qualified to provide music therapy services.

Where Do Music Therapists Work?

Music therapists offer services in medical hospitals, skilled and intermediate care facilities, rehabilitation hospitals, adult day care centers, senior centers, hospices, psychiatric treatment centers, drug and alcohol programs, schools and other facilities. In pain management applications, music therapists can work in many different hospital units, including ICU, NICU, Pre- and Post-Op, surgery, cardiac care, obstetrics, emergency, pediatrics, physical rehabilitation, and outpatient programs. Some therapists are self-employed and work on the basis of independent contracts, while others are salaried hospital employees.

How Can You Find a Music Therapist or Get More Information?

American Music Therapy Association
8455 Colesville Road, Suite 1000
Silver Spring, MD 20910
Phone: (301) 589-3300
Fax: (301) 589-5175
Web: www.musictherapy.org
Email: info@musictherapy.org

American Music Therapy Association, Inc.

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email: amta@musictherapy.org website: www.musictherapy.org

MUSIC THERAPY AND ALZHEIMER'S DISEASE

"...[W]e lose sight of how powerful melody and rhythm can be in the realm of medicine, particularly with respect to Alzheimer's patients and their caregivers... nursing homes and hospitals are finding that working with a music therapist can make a big difference..."

- C. Gorman. Time, November 14, 2005

What Is Music Therapy?

Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapy interventions can be designed to promote wellness, manage stress, alleviate pain, enhance memory, improve communication, and provide unique opportunities for interaction. Research in music therapy supports the effectiveness of interventions in many areas such as facilitating movement and overall physical rehabilitation, increasing motivation to engage in treatment, providing emotional support for clients and their families, and creating an outlet for expression of feelings. Because music therapy is a powerful and non-threatening medium, unique outcomes are possible.

How Does Music Therapy Make A Difference For Older Persons?

Music therapy treatment is efficacious and valid with older persons who have functional deficits in physical, psychological, cognitive or social functioning. Research results and clinical experiences attest to the viability of music therapy even in those who are resistive to other treatment approaches. Music is a form of sensory stimulation, which provokes responses due to the familiarity, predictability, and feelings of security associated with it.

What Do Music Therapists Do?

After assessing the strengths and needs of each client, qualified music therapists develop a treatment plan with goals and objectives and then provide the indicated treatment. Music therapists structure the use of both instrumental and vocal music strategies to improve functioning or facilitate changes that contribute to life quality. They may improvise or compose music with clients, accompany and conduct group music experiences, provide instrument instruction, direct music and movement activities, or structure music listening opportunities. Music therapists are usually members of a health care interdisciplinary team and they implement programs with groups or individuals that display a vast continuum of needs, from leisure time classes and community involvement to bedside care.

Where Do Music Therapists Work?

Music therapists offer services in skilled and intermediate care facilities, adult foster care homes, rehabilitation hospitals, residential care facilities, hospitals, adult day care centers, retirement facilities, senior centers, hospices, senior evaluation programs, psychiatric treatment centers, and other facilities. Music therapists also work for agencies that provide in-home care. Some therapists are self-employed and provide individual and group music therapy services on a contract basis.

What Can One Expect From A Music Therapist?

When individualized music experiences are designed by a professionally trained music therapist to fit functional abilities and needs, responses may be immediate and readily apparent. Participants without a music background can benefit from music therapy.

Music therapy provides opportunities for:

- Memory recall which contributes to reminiscence and satisfaction with life
- Positive changes in mood and emotional states
- Sense of control over life through successful experiences
- Awareness of self and environment which accompanies increased attention to music
- Anxiety and stress reduction for older adult and caregiver
- Nonpharmacological management of pain and discomfort
- Stimulation which provokes interest even when no other approach is effective
- Structure which promotes rhythmic and continuous movement or vocal fluency as an adjunct to physical rehabilitation
- Emotional intimacy when spouses and families share creative music experiences
- Social interaction with caregivers and families

Who Is Qualified As A Music Therapist?

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How Does Music Therapy Help Families?

Music therapy provides:

- A forum to share common experiences and enjoyment as a couple or family
- Meaningful time spent together in a positive, creative way
- Relaxation for the entire family
- Stimulation for reminiscence of family bonds
- Unity and intimacy for families through verbal and nonverbal interaction
- Respite for the caregiver

Why Music Therapy?

The wife of a man with severe dementia said, "When I was encouraged by a music therapist to sing to my husband who had been lost in the fog of Alzheimer's disease for so many years, he looked at me and seemed to recognize me. On the last day of his life, he opened his eyes and looked into mine when I sang his favorite hymn. I'll always treasure that last moment we shared together. Music therapy gave me that memory, the gift I will never forget."

Dr. Oliver Sacks, at the Hearing before the Senate Special Committee on Aging entitled, "Forever Young: Music and Aging," stated: "The power of music is very remarkable... One sees Parkinsonian patients unable to walk, but able to dance perfectly well or patients almost unable to talk, who are able to sing perfectly well... I think that music therapy and music therapists are crucial and indispensable in institutions for elderly people and among neurologically disabled patients."

A gentleman in the early stages of progressive dementia improvised on a xylophone during a music therapy session to express his feelings, and then stated: "I don't know how anyone can live without music."

A frail 93 year old woman, referred for music therapy after being diagnosed with major depression, said: "Now, there is no need to be morose. I can have my music here with me and listen to it whenever I want to feel young."

When a couple danced together for the first time after five years of the husband's deterioration from probable Alzheimer's disease, the wife said: "Thank you for helping us dance. It's the first time in three years that my husband held me in his arms." Tearfully, she said that she had missed him just holding her and that music therapy had made that possible.

What Is AMTA?

The American Music Therapy Association (AMTA) represents over 5,000 music therapists, corporate members, and related associations worldwide. AMTA's roots date back to organizations founded in 1950 and 1971. Those two organizations merged in 1998 to ensure the progressive development of the therapeutic use of music in rehabilitation, special education, and medical and community settings. AMTA is committed to the advancement of education, training, professional standards, and research in support of the music therapy profession. The mission of the organization is to advance public knowledge of music therapy benefits and increase access to quality music therapy services. Currently, AMTA establishes criteria for the education and clinical training of music therapists. Members of AMTA adhere to a Code of Ethics and Standards of Practice in their delivery of music therapy services.

How Can You Find A Music Therapist Or Get More Information?

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Is There Research To Support Music Therapy For Persons with Alzheimer's Disease?

Through peer-reviewed journals inside the profession such as the Journal of Music Therapy, Music Therapy, and Music Therapy Perspectives, and extensive articles in journals outside the profession, AMTA has promoted much research exploring the benefits of music therapy for persons with Alzheimer's Disease.

Research Highlights

- Music therapy reduces depression among older adults.
- Music experiences can be structured to enhance social/emotional skills, to assist in recall and language skills and to decrease problem behaviors.
- Music tasks can be used to assess cognitive ability in people with Alzheimer's Disease.
- Music is effective in decreasing the frequency of agitated and aggressive behaviors for individuals diagnosed with Alzheimer's Disease and related dementias.
- Individuals in the late stages of dementia respond to and interact with music.

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MUSIC THERAPY AND MEDICINE

"I certainly think that every institution should have its music therapy and its music therapists."
- Oliver Sacks, MD, Neurologist

What Is Music Therapy?

Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. It is an established health service similar to occupational therapy and physical therapy and consists of using music therapeutically to address physical, psychological, cognitive and/or social functioning for patients of all ages. Because music therapy is a powerful and non-invasive medium, unique outcomes are possible. In addition to its applications with hospital patients, music therapy is used successfully with persons of all ages and disabilities.

How Does Music Therapy Make A Difference For Medical Patients?

Music therapy has been shown to be an efficacious and valid treatment option for medical patients with a variety of diagnoses. Music therapy can be used to address patient needs related to respiration, chronic pain, physical rehabilitation, diabetes, headaches, cardiac conditions, surgery, and obstetrics, among others. Research results and clinical experiences attest to the viability of music therapy even in those patients resistant to other treatment approaches. Music is a form of sensory stimulation, which provokes responses due to the familiarity, predictability, and feelings of security associated with it.

What Do Music Therapists Do?

Music therapists use music activities, both instrumental and vocal, designed to facilitate changes that are non-musical in nature. Music therapy programs are based on individual assessment, treatment planning, and ongoing program evaluation. Frequently functioning as members of an interdisciplinary team, music therapists implement programs with groups or individuals addressing a vast continuum of outcomes, including reduction of pain and anxiety, stress management, communication, and emotional expression.

What Can One Expect From A Music Therapist?

Music therapy utilized in a medical setting complies with the expectations and requirements inherent in the medical model of treatment. Professionally trained music therapists design and utilize individualized music experiences to assess, treat, and evaluate patients. Music therapy patient objectives are specific and relevant to medical diagnosis, course of treatment, and discharge timeline. Benefits are described in medical, and not musical, terms.

Through a planned and systematic use of music and music activities, the music therapist provides opportunities for:

- Anxiety and stress reduction
- Nonpharmacological management of pain and discomfort
- Positive changes in mood and emotional states
- Active and positive patient participation in treatment
- Decreased length of stay
-

In addition, music therapy may allow for:

- Emotional intimacy with families and caregivers
- Relaxation for the entire family
- Meaningful time spent together in a positive, creative way

Who Is Qualified As A Music Therapist?

Graduates of colleges or universities from more than 70 approved music therapy programs are eligible to take a national examination administered by the Certification Board for Music Therapists (CBMT), an independent, non-profit certifying agency fully accredited by the National Commission for Certifying Agencies. After successful completion of the CBMT examination, graduates are issued the credential necessary for professional practice, Music Therapist-Board Certified (MT-BC). In addition to the MT-BC credential, other recognized professional designations are Registered Music Therapists (RMT), Certified Music Therapists (CMT), and Advanced Certified Music Therapist (ACMT) listed with the National Music Therapy Registry. Any individual who does not have proper training and credentials is not qualified to provide music therapy services.

Where Do Music Therapists Work?

Music therapists offer services in medical hospitals, skilled and intermediate care facilities, rehabilitation hospitals, adult day care centers, senior centers, hospices, psychiatric treatment centers, drug and alcohol programs, schools and other facilities. In the medical setting, music therapists work with a variety of patient needs, and may work in many different hospital units, including ICU, NICU, Pre- and Post-Op, surgery, chronic pain management, cardiac care, obstetrics, emergency, pediatrics, physical rehabilitation, and outpatient programs. Some therapists are self-employed and work on the basis of independent contracts, while others are salaried hospital employees.

How Does Music Therapy Help Patients And Health Care Staff?

Dr. Walter Quan, Jr., Oncologist-Hematologist of St. Luke's Medical Center in Cleveland, Ohio, attests that:

> *"Music therapy has a wide range of applications. We see some patients whose blood pressure does come down and seems to stay down through regular use of music therapy. Another important aspect is the use in the labor and delivery room. We know that patients, who go through Lamaze training for instance, can also use music therapy to help them relax and to have pain relief in terms of labor pains."*

Music therapy is quantifiable and qualitative. Dr. Quan continues:

> *"... [I]n general as a physician you only use those things that you can measure or that have a number related to [them]... but there are a number of disciplines, and music therapy is one of them, where there is a qualitative effect which can give a lot of benefit for patients."*

Music therapists complete assessments for each patient and collect extensive data in order to write a complex patient history and develop a client-centered treatment plan. The music therapist is then able to evaluate the patient during the course of treatment. All of this contributes to the quantifiability of music therapy treatment.

Music therapy interventions are favored for the ability to meet quality of life needs. As quality of life issues and patient choice are pushed to the forefront of the national healthcare agenda, music therapy is being increasingly recognized for its unique contribution to patient quality of life.

Music therapy can help to relieve pain and reduce stress and anxiety for the patient, resulting in physiological changes, including:

- Improved respiration
- Lower blood pressure
- Improved cardiac output
- Reduced heart rate
- Relaxed muscle tension

Music therapy has been shown to have a significant effect on a patient's perceived effectiveness of treatment, self reports of pain reduction, relaxation, respiration rate, behaviorally observed and self-reported anxiety levels, and patient choice of anesthesia and amount of analgesic medication.

Why Music Therapy?

William Frohlich, President, Beth Abraham Health Services in New York, talks about music therapy as part of the total treatment modality:

> *"I think that the therapist plays an integral team role when you are talking about a team of physicians, a team of nurses, therapists, physical or occupational therapists and so on... included in that team needs to be a music therapist. The observations where a patient may be singing where they could not speak before or they may be walking or dancing where they could not move before – that is important for the music therapist to bring to the occupational therapist or physical therapist to become part of the total treatment modality."*

Dr. Walter Quan, Jr., Hematologist-Oncologist, St. Luke's Medical Center in Cleveland, Ohio, on music therapy in the treatment of cancer:

> *"The mind/body relationship is particularly important in terms of looking at the immune system to treat cancer. We believe that patients who are under less stress, who are in a brighter mood, appear to do better in terms of their anti-cancer therapy. I think that music therapy and imaging and immune therapy of cancer all tie together... I think it can be helpful in conjunction with biologic therapy for cancer. A study done just relatively recently on cancer patients showed that approximately three quarters of cancer patients that had their usual pain medicines but also had the additional music therapy experienced less pain then previously... Music therapy in helping patients relax could possibly be beneficial in raising the innate immune system which could have therapeutic implications for cancer."*

Susan Shurin, M.D., Chief of Pediatric-Hematology, Oncology at the Ireland Cancer Center in Cleveland, Ohio, comments on the effectiveness of music therapy in treatment of neurological impairments:

> *"Music therapy enables people to sometimes put words together in ways that are hard for them to do otherwise. ...[I]t often seems to be easier if [the patient] has*

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Virtual Reality Program and Policy & Procedure

CONTINUUM	VIRTUAL REALITY	Effective: 9/1/2019
	Patient Services	Policy No.:

PURPOSE

To ensure that virtual reality is provided to hospice patients in a safe manner according to established professional standards.

POLICY

Continuum offers virtual reality (VR) to identified patients who might benefit from expected outcomes such as, but not limited to:

1. Improved quality of life
2. Decreased anxiety
3. Improved comfort

Virtual reality is provided by Continuum personnel or volunteers who are specifically trained in presenting and operating the equipment for maximum benefit to the patient.

PROCEDURE

1. Virtual Reality services are discussed with patients and families at the start of care. Since VR may be contraindicated, not all patients are candidates and the hospice nurse or member of the IDG and physician will discuss suitability if the patient/legal representative are interested in this service. Any member of the IDG may refer the patient for virtual reality services, upon request of the patient/family/legal representative, or if the IDG member determines the patient may benefit as part of the plan of care.

2. Continuum personnel, including volunteers, who will be presenting and/or operating the equipment, will receive orientation and training to the equipment and VR headset. Training will include the history and science behind VR, as well as education about its benefits and risks, and a return demonstration to ensure competency. Use of the system themselves is encouraged, unless contraindicated. Documentation of training will be maintained in the personnel file.

3. An order from the Continuum Hospice Physician must be received prior to initiation of VR sessions. VR may be contraindicated or may need to be limited in patients with

   A. Monocular Vision
   B. Seizures
   C. Severe Vertigo/Vestibular
   D. Impairment
   E. Orientation
   F. Simulation Sickness
   G. Limited Head and Neck strength

H. Health conditions that can be exacerbated with use
I. Predisposition to overstimulation
J. Prolonged Usage
K. Traumatic Brain Injury
L. Stroke
M. Spinal Cord Injury
N. PTSD/ Mental Health

4. Prior to beginning the VR session, a member of the interdisciplinary Group (ie. RN Case Manager, Licensed Social Worker, or Spiritual Care Coordinator) will explain and document that the patient/legal representative understands the risks and potential benefits of VR and agrees to the VR experience.

5. The patient and/or their family/legal representative will have an opportunity to participate in the plan of care around the VR experience. Goals, interventions and progress toward goals will be documented in the patient's record according to Continuum's documentation policies and procedures.

6. Explain the VR experience to the patient at the start of the VR session, familiarizing them with the VR headset and any sensations they may feel. Let them know how long the session will last. Ensure they understand how to communicate a signal to stop the session if they encounter problems.

7. Take the time to ensure that the VR headset fits the patient and is not too tight or heavy. Be familiar with the adjustments that the hardware and software are capable of. The most crucial component of visual comfort is the ability to adjust the interpupillary distance (IPD).

8. Because the VR headset "occludes" or covers a patient's view of the physical world, the space where they use VR should be clear of potential obstructions that patients may easily trip over, bump into, or hit their head on, and should be free of cables, people, small children, and pets. Be sure, if they are sitting in a chair, that it is stabilized. If unable to move a wheelchair bound patient to an armchair, be sure all wheels are fully locked before the session begins.

9. Test the patient's success and tolerance to VR in the initial session after 15 minutes. A maximum session time of 60 minutes is an advisable upper limit. Breaks between sessions are recommended for at least 10–15 minutes.

10. VR headsets must be disinfected between patient uses, or individual headsets may be used for each patient. Manufacturer guidelines must be followed if available for disinfection practices. If unavailable, see Continuum policies for disinfecting equipment. Impermeable barriers, such as shower caps or cellophane, may be suitable for use on the VR headset when the headset contains a foam cushion or recessed area which is difficult to sanitize.

11. Bereaved Client Activities are documented in accordance with Continuum policies and procedures. (See Patient Services Policies: Bereavement Services). Progress notes enable the instructor/equine specialist in mental health and learning to document the

participant's achievements and problem areas. It provides a method to re-evaluate and build upon previous goals and objectives.

12. EFP professionals will be Continuum personnel or volunteers and oriented according to Continuum policies and procedures. EFP professionals will participate in hospice inservice programs as well as continuing education to maintain and improve their specialized skills.

13. EFP professionals may participate in IDG meetings and quality assessment performance improvement teams.

Equipment recommendations:

Virtual reality equipment should be designed to comply with safety and EMC standards applicable to Information Technology Equipment. The VR headset should be tested and certified as free from causing electromagnetic interference (IEC/EN-60601-1 and -2 series approved, not just tested)

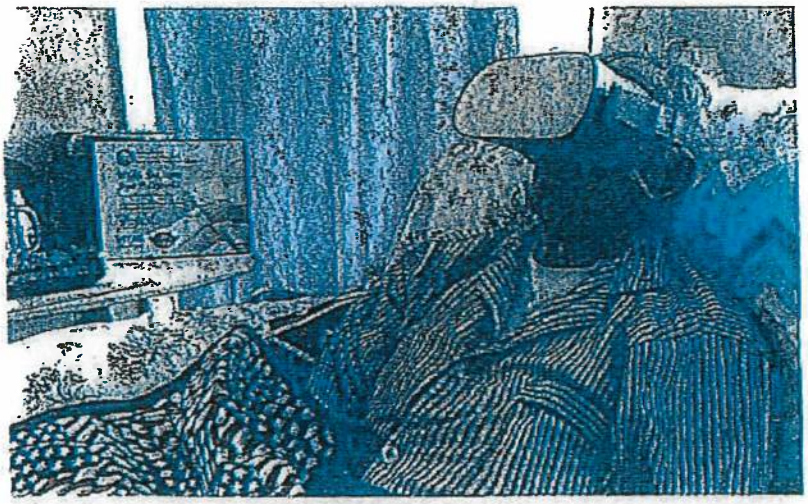
VIRTUAL REALITY	Policy Number:
CHAP Standard(s):	
Federal Regulatory Citation:	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 9/1/2019	

It's not complicated
Everyone deserves our best de
on every iPhone

How families are giving a fantastic trip to loved ones in hospice

"How is heaven going to be better than that?"

Erin Carson May 16, 2019 3:53 p.m. PT



A hospice patient uses a virtual reality headset.
VITAS Healthcare

When hospice nurse Laurie McKay arrived at the emergency room, her patient – a man in his early sixties with terminal cancer and now a fractured hip – told her: "I knew you would be coming someday, but today my wife and I were supposed to be getting on a cruise ship."

McKay, who is chief nursing educator for Continuum Care Hospice based in the San Francisco Bay Area, didn't want the couple to miss out on that last cruise to Alaska together, so she turned to a tool that Continuum had started using with its patients – virtual reality.

She made an appointment to visit the couple once they were back at home. Using Samsung Gear VR headsets and Google Earth VR, she'd

Bucket lists get 00:05 / 01:42

"These were experiences he thought he would never be able to see completed," McKay said.

While you might think of virtual reality as something used for games and marketing gimmicks, it's also found its way into a variety of other industries, including health care. The virtual reality market for health care alone is supposed to hit $6.91 billion by 2026, according to a March report from Reports and Data.

VR may get a bad rap as a once-hot tech trend that failed to live up to expectations, but companies haven't given up on it. Facebook last month released the $400 Oculus Quest, which CNET editor Scott Stein called the best thing he's tried this year. And virtual reality has made headway outside of the consumer world.

For example, using VR for hospice care -- as a way to bring a larger world to people who've found themselves limited to a room, or just a bed -- is beginning to catch on with care providers. It can be a way to check off bucket list items, like visiting London, swimming with dolphins or even skydiving. It can also complement therapy and counseling, and even perhaps help manage pain.

Plugging in

To bring VR to its patients in the past year or so, Continuum partnered with Rendever, a company that focuses on virtual reality for seniors.

Rendever provided Continuum with headsets and tablets that allow the person running the session to guide the experience. The company has a library of mostly third-party VR experiences to choose from, and a flagging system they've created that lets care givers know that an app might not be suitable for someone with a history of post-traumatic stress disorder, motion sickness or the like. What's more, two people can even simultaneously experience the same app wearing separate headsets.

> "She took off the goggles and she said, 'How is heaven going to be better than that?'"
>
> *Ben Roby, a chaplain at Hospice of North Central Ohio*

That ability to share the experience is an important factor. Rendever CEO Kyle Rand spoke about the prevalence of social isolation among

Rand said.

Elsewhere in the country, hospice care providers are sussing out how to use virtual reality on their own.

Ben Roby, a chaplain at Hospice of North Central Ohio and the self-professed resident tech nerd, started looking into VR about a year ago when the director of development approached him about it.

After doing a lot of research and getting a grant from a local philanthropic organization, Roby settled on a Windows Mixed Reality headset and an Oculus Go.

Oculus Quest is fully mobile VR

See all photos

+40 More

In the four and a half months he's had VR out in the field with him (at this point, he doesn't leave home without it), Roby said most patients who try it want to use it again. One patient, a 91-year-old woman, last week put in a request for cliff diving.

But beyond seeking thrills, finding calm or just doing cool stuff in VR, Roby said it's also helped him bridge some of the more serious conversations patients might eventually have with a chaplain.

In once instance, he showed a woman Angel Falls in Venezuela, which is the highest waterfall in the world.

Bucket lists get 00:05 / 01:42

"She took off the goggles and she said, 'How is heaven going to be better than that?'" he said. "As a chaplain, that's just kicking the door wide open for me to be able to dialog with her about end-of-life issues."

Beyond the bucket list

Fulfilling a bucket list item or discussing spiritual matters aren't the only ways hospice care providers are using VR.

Researchers at the University of Washington were using VR to help burn victims get through painful wound dressing more than a decade ago. A 2017 study from Cedars-Sinai found that patients using virtual reality as a distraction reported a 24 percent drop in the severity of their pain.

VR gets arty at Tribeca Film Festival 2019

See all photos

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Rod Cruz, AT&T's general manager of Healthcare Industry Solutions, said VR for pain management could be a preferable option "rather than making people comfortably numb with opiates and other things to numb pain."

Vitas and AT&T are starting in California with 15 clinicians who'll have Magic Leap and Oculus Go headsets. Vitas CIO Patrick Hale expects that will translate into hundreds of patients using the devices. From all those interactions, they're hoping to come away with perspective on the best types of experiences to use, the ideal length, and data on the effects of VR on respiratory rate, pulse and blood pressure. Within six to nine months, Hale wants to have a developed and modified a therapy program that can be used by Vitas across the country.

Cruz said having access to 5G mobile hotspots to run 4K VR could cut down on lag and improve the VR experience. The next generation of cellular technology, however, is only in the early stages of deployment, so the kind of coverage that would need to be in place for this could still be years away.

VR's impact

VR might not be a magic potion -- there will be folks who don't want to mess around with new tech, or who would be prone to nausea and motion sickness that sometimes accompany laggy virtual reality experiences. For others, poor vision may be a hurdle.

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who came to visit him about the VR experience. And when he died, she even talked about it at his service.

"[He thought] he was going to end up simply being in a bed in his home waiting to die," McKay said. "Instead he found he was able to live and participate and find enjoyment each day that he was given."

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COMMENTS

Tech Enabled | Science

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Equine Therapy and Policy & Procedure

CONTINUUM	EQUINE THERAPEUTIC SERVICES	Effective: 9/1/2019
	Patient Services	Policy No.:

PURPOSE

To ensure that equine therapeutic services are provided to hospice patients, families/caregivers and bereaved clients in a safe manner according to established professional standards.

DEFINITIONS

Equine-facilitated psychotherapy (EFP) is defined as an interactive process in which a licensed mental health professional working with or as an appropriately credentialed equine professional partners with suitable equine(s) to address psychotherapy goals set forth by the mental health professional and the client.

Equine-Assisted Therapy (EAT) – therapy or treatment that incorporates equine activities and/or the equine environment. Rehabilitative or habilitative goals are related to the client's needs and the medical professional's standards of practice.

Equine-Assisted Learning (EAL) – Equine-assisted learning (EAL) is an experiential learning approach that promotes the development of life skills applicable to educational, professional or personal goals through equine-assisted activities.

Therapeutic Activity – an activity from which a participant derives benefit. An activity can be therapeutic without being considered a therapy or treatment. In general, equine-assisted activities may be described as therapeutic but are not considered therapy without fulfilling specific requirements

POLICY

Continuum provides Equine Facilitated Hospice and Bereavement care through ground activities facilitated by an EFP Professional (i.e. certified Equine Specialist in Mental Health and Learning). EFP is provided to active patients when ordered by a physician and to both active patients or bereaved clients when not contraindicated.

EFP meets needs identified by the Interdisciplinary Group in the hospice patient's plan of care or the bereaved client's bereavement plan of care, by offering an approach to spiritual and emotional well-being that allows an opportunity for, but not limited to, the following:

1. Exploration of meaning at end-of-life
2. Mind, body, spirit connection
3. Multi-sensory awareness and mindfulness
4. Coping with grief and loss
5. Increase in well- regulated feelings
6. Healing connections in relationship
7. Increase in spiritual joy and awe

8. Increase in self-confidence and well being

Equine therapeutic services are discussed at the start of care and at the time bereavement services are offered and referrals may be made by the admission nurse, RN Case Manager, SW or Physician.

Information about bereaved clients is considered confidential and will be treated under Continuum's privacy and confidentiality policies and procedures and as regulated by federal, state and local regulations, including requests from outside sources for release of information.

PROCEDURE

1. Signed informed consent is obtained before beginning EFP services. This document describes the EFP professional's credentials and philosophy for including equines in psychotherapeutic treatment, as well as the goals and services to be provided.

2. Active patients and bereaved clients who require physical assistance with toileting or ambulation will be accompanied by a caregiver, who is familiar with the needs of the patient, i.e. either their own personal caregiver (paid or unpaid) or a Continuum Hospice RN, LPN/LVN, or HA, who can provide assistance with toileting, ambulation, transfer or other care needs while on site receiving equine therapeutic services.

3. A signed, dated, written waiver or release of liability is obtained from all patients, bereaved clients, personnel or volunteers (or their legal representatives), including those who will be assisting or accompanying the patient/bereaved client in equine activities.

   FL Specific: The documents described above shall contain the following warning notice:

   WARNING

   Under Florida law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

   MA Specific: The signs and contracts described above shall contain the following notice:

   WARNING: Under Massachusetts law, an equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities, pursuant to section 2D of chapter 128 of the General Laws.

   RI Specific: The signs and contracts described above shall contain the following warning notice:

   WARNING

   Under Rhode Island Law, an equine professional, unless he or she can be shown to have failed to be in the exercise of due care, is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities, pursuant to this chapter.

4. A completed and signed health history will be obtained from the Bereaved Client that provides pertinent health history information that may impact participation in equine activities, including conditions which may limit or contraindicate participation in equine activities.

5. Contraindications include, but are not limited to, allergies to horses and patient's inability to be transported to the barn. The existence of a condition may require further investigation to determine if equine activities are inappropriate or if they may progress with evaluation at regular intervals. This investigation may include contacting the individual's physician or therapist/mental health professional. Refusal to give permission to investigate the condition will result in a determination that equine activities are contraindicated.

6. Horses

   A. Horses are sentient beings and will be treated with care and respect.

   B. Horses will be treated as a member of the therapeutic team and will be given time after patient/bereaved client encounters to return to their herd for their well-being.

   C. All horses will be evaluated for well-being prior to encounters.

   D. All horses will be screened for safety and non-reactivity.

   E. All horses will be desensitized to wheelchairs, walkers, oxygen tanks, and other medical devices that will be used by patients/bereaved clients.

   F. Selection of equine - Suitable horses include those that look to a person for direction, react moderately to stimuli, show a desire to connect to or curiosity about humans, and are trusted by the ESMHL.

   G. The equine specialist will be responsible for safe handling of the horse at all times.

7. Prior to each session, and based on the needs, size, type of movement or activity expected/provided by the equine, size of the equine, and plan for the activity, the equine specialist is responsible for ensuring appropriate selection of:

   A. Equipment for equine

   B. Equipment for participant

   C. Staff and volunteer assignments

8. Safety checks are conducted at the beginning of each activity. The ESMHL may designate a trained assistant to perform safety checks.

9. All injuries, accidents, "near misses", adverse events, complaints and other occurrences will be documented according to Continuum's policies and procedures. (See Quality Assessment and Performance Improvement Policies: Incident Reporting, Adverse Events, Complaint Process)

10. Barn

A. The barn owner(s) will sign a vendor and business associate agreement with Continuum.

B. The barn owner will comply with federal and state regulations regarding equine encounters.

C. The barn owner will provide a clean, safe environment for participants and horses.

D. The barn will include a private area suitable for conducting a confidential interview or processing session. This space may be needed for a participant who is unable/unwilling to participate in equine activities, is decompensating physically or behaviorally or just needs a confidential place to process emotions or grieve. The space does not have to be an office but should offer a place to sit down and have a private conversation.

E. The barn and lavatories will be accessible for wheelchairs and walkers.

11. When EFP is provided to patients and/or families or caregivers who are active hospice patients, the EFP professional will contribute to the comprehensive assessment and ongoing updates to the comprehensive assessment based on the needs of the patient. Assessment activities will include general categories of the psychosocial and/or spiritual assessments relevant to determining responses to equine activities, planning appropriate interventions and establishing patient specific goals and outcomes.

EFP assessments and interventions will be documented in the patient's clinical record as part of the comprehensive assessment and in interdisciplinary visit notes, as well as the plan of care. Documentation will include:

1) Goals of care

2) Observations of the needs or problems of the patient and family/caregiver, as identified in assessments

3) Interventions provided to address the needs or problems of the patient and family/caregiver, and

4) Patient's and/or family/caregiver's response and progress towards goals

11. Bereaved Client Activities are documented in accordance with Continuum policies and procedures. (See Patient Services Policies: Bereavement Services). Progress notes enable the instructor/equine specialist in mental health and learning to document the participant's achievements and problem areas. It provides a method to re-evaluate and build upon previous goals and objectives.

12. EFP professionals will be Continuum personnel or volunteers and oriented according to Continuum policies and procedures. EFP professionals will participate in hospice inservice programs as well as continuing education to maintain and improve their specialized skills.

13. EFP professionals may participate in IDG meetings and quality assessment performance improvement teams.

EQUINE THERAPEUTIC SERVICES	Policy Number:
CHAP Standard(s):	
Federal Regulatory Citation:	
State/Local Regulatory Citation: Fla. Stat. § 773.05 (1993); Massachusetts Gen Laws 128 §2D; Rhode Island Laws Ch. 21, §4-21-1	
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Equine-Assisted Intervention for People with Dementia

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ABSTRACT The purpose of this exploratory study was to determine the feasibility and effectiveness of using guided interactions with horses as a nonpharmaceutical intervention to improve the physiological and behavioral states of persons with dementia. A convenience sample of persons with dementia was recruited from an adult day health center ($n = 16$). A multi-component intervention was implemented comprised of opportunities for grooming, painting, and leading horses. Using a randomized pretest-posttest crossover design, researchers compared participants receiving the equine-assisted intervention with participants receiving treatment as usual. Older persons with Alzheimer's disease and related dementias engaged positively in animal-assisted therapy with horses. A reduction in behavioral problems was found post intervention in contrast to the comparison group. Pre-intervention measures showed that participants exhibited lower levels of disruptive behaviors compared with the control group on the days they were scheduled to work with the horses. Interestingly, cortisol levels, used as a physiological measure of coping with stress, were elevated after the intervention in participants with higher Mini Mental State Examination scores. Equine-assisted interventions are feasible and possibly beneficial for adults with Alzheimer's disease or a related dementia disorder, such as those enrolled in adult day health programs. Future studies should utilize multiple methods of assessing impact and include process measures to delineate which specific activities seem to provide the most benefit.

Keywords: adult day care, Alzheimer's disease, cortisol, dementia, elderly, equine-assisted therapy

The number of individuals with Alzheimer's disease (AD) has increased significantly over the last decade, and this number will likely increase as baby boomers age. Currently, there are 5.4 million

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individuals with AD in the United States, and by 2050, this number is predicted to grow to 16 million people (National Alzheimer's Association 2012). AD is characterized by progressive cognitive and behavioral decline, ultimately resulting in death. Significant personal, social, and financial costs are associated with AD. Pharmaceutical interventions are used to reduce symptoms. However, for those with dementia, side-effects from medication can diminish their quality of life. Although pharmacological therapy is the mainstay of treatment, non-pharmacological interventions often are suggested for physiological (e.g., anxiety, depression, irritability) and behavioral challenges (e.g., agitation, aggression, sleep disturbances) associated with AD. Behavior management therapies, cognitive stimulation, caregiver support, and staff education show the most promise of impacting mood, thought, and behavior of persons with dementia (Livingston et al. 2005).

Caregivers and care recipients with dementia may utilize adult day services (ADS) to receive care and respite. ADS programs provide health, social, nutritional, and recreational services during day-time hours. Approximately 47% of ADS participants nationally have some level of dementia. Many participants also face physical disabilities (42%) and various chronic health care conditions such as diabetes (31%) and cardiovascular disease (34%). ADS are the primary community-based care option for caregivers and individuals with dementia (Anderson, Dabelko-Schoeny and Johnson in press) and can act as a platform for testing innovative non-pharmacological interventions for persons with dementia.

Animal-assisted therapy or AAT is a sub-type of "animal assisted interventions" that corresponds to practices that generate change (or learning), allowing people to improve their quality of life (Grandgeorge and Hausberger 2011). AAT has been defined as "a formal goal-directed intervention in which a therapy animal is an integral part of the treatment process. This service is delivered by a health or human service professional working within the scope of his or her professional role" (Fine 2002). AAT is expected to have three effects: (1) psychological (e.g., relaxation, motivation); (2) physiological (e.g., improvement of vital signs through neuroendocrine modulation), and (3) social (e.g., stimulation of communication among patients and caregivers).

The aim of this exploratory study is to evaluate the feasibility and the effect of equine-assisted therapy on the physiological and behavioral states of persons attending ADS with AD or related dementias.

Background

AAT has been used in nursing homes with older adults for the purposes of rehabilitation and positive engagement (Gammonley and Yates 1991). Specifically for older persons with dementia, the presence of therapy animals has been useful in reducing agitated behavior, decreasing episodes of verbal aggression and anxiety, and increasing social interaction (Fick 1993; Fritz et al. 1995; Richardson 2003). Evidence suggests that AAT with dogs can reduce agitation, irritability, anxiety, depression, and sleep disturbances in persons with dementia. In addition, when persons with AD engage in canine AAT, they experience an increase in social engagement and communication (Kogan 2001; Sellers and Smith 2002; Richeson 2003; Filan and Llewellyn-Jones 2006). What is not clear is whether individuals with AD could also experience similar benefits through equine-assisted therapy. Many unanswered questions remain about the complexities of the human–horse relationship and associated patterns of hormonal and behavioral responses to this relationship (DeVries, Glasper and Detillion 2003).

Psychosocial benefits, such as improvements in self-confidence, among children with disabilities as the result of horseback riding, have been reported anecdotally as long ago as

1970 (Harpoth 1970). Recent studies on equine-assisted therapy have reported psychosocial benefits for various groups of younger persons including self-confidence, interest in learning/motivation to participate, improvement in attention span/concentration/listening skills and verbal skills (MacKinnon, Noh and Laliberte 1995; Wuang et al. 2010; Kwon et al. 2011). In these studies, equine-assisted activities range from handling, grooming, driving, longeing, riding and/or vaulting. What has not been studied is whether these derived benefits from equine-assisted therapy can be experienced by older individuals with dementia.

The hypothalamic-pituitary-adrenal axis (HPA axis) is the body's main physiological system that controls response to stress. It acts through the hormone cortisol, which is produced in the adrenal cortex and affects many tissues including the brain. Cortisol is secreted in a distinct daily diurnal pattern whereby cortisol levels rise rapidly after awakening, peaking around 30 minutes post-awakening and declining thereafter reaching a nadir in the evening (Pruessner et al. 1997). In the short term, following a stressful experience, blood cortisol levels rapidly increase, and its presence is helpful in improving short-term memory formation and adapting the body's physiology to deal with the situation effectively. However, long-term stress leads to prolonged elevated levels of circulating endogenous cortisol, which can have serious deleterious effects.

Advances in neuroendocrinology have refined our understanding of the relationships among stress, aging, and cortisol (McEwen 2007). Over 20 years ago it was discovered that patients with AD had elevated levels of circulating cortisol, compared with healthy individuals. Increased cortisol levels, as reflected by morning plasma cortisol concentrations, are associated with more rapid rates of disease progression as demonstrated by both clinical and cognitive measures (Csernansky et al. 2006; Huang et al. 2009). Therefore, incorporating equine-assisted therapy as a complimentary intervention with pharmaceutical therapy may prove beneficial in slowing the progression of AD.

To our knowledge, there are no published studies that investigate the use of equine-assisted therapy for elderly patients with AD or other related dementias. As different animal species may stimulate different effects on humans and might represent different therapeutic potential, we hypothesized that a short-term, non-pharmaceutical equine-assisted therapy would provide change to the cortisol levels and disruptive behaviors of individuals receiving services in a dementia care setting. The goals of the study were to develop an equine-assisted therapy intervention and test its effect on the physiological and behavioral symptoms of older adults with AD or other related dementias who attend ADS.

Methods

Design

This study employed a randomized pretest-posttest crossover design to gauge the effectiveness of a short-term intervention intended to provide equine-assisted therapy to ADS participants with AD. In this design, one randomly selected group received the intervention while the second group served as the comparison group, in this case receiving services as usual in the ADS program. Services as usual included: crafts, rest periods, exercise, or discussion groups. The second group then received the intervention while the intervention was withdrawn from the first group, for comparison purposes. This design is advantageous in that it allows for multiple periods of control and enables all participants to receive the intervention.

Participants

Participants included persons with AD who were attending one ADS center in a Midwest metropolitan area of the United States. All clients of the ADS have access to daily transportation via the center's shuttle bus service to the center and from the center to their homes. The same center shuttle buses and drivers were used for transportation of the clients to the farm for the intervention program. Participants were part of either the "Meadow" or "Glen" program. The Meadow program includes individuals with more limited functioning and communication skills, and the Glen program includes those who are higher functioning. Both programs include individuals with dementia diagnoses. The staff of the ADS center screened clients for participation. Inclusion criteria were: being able to ambulate (by walking or wheel chair), receiving a stable regimen of medications (including psychotropic medications), and being diagnosed with early to moderate stage AD or related dementia. Sixteen clients met the inclusion criteria. Both participant and proxy (primary caregiver) consent was received. Participation in the study was voluntary and the participant could withdraw from the study at any time. Once the pool of participants was identified, each individual was randomly assigned to either the first or second intervention period group using a computer-generated list of random numbers.

Demographic data were abstracted from each participant's medical record, including age, gender, ethnicity, medications, and diagnosis. Mini Mental State Examination (MMSE) was used to verify cognitive status. The MMSE is a widely used short mental status instrument that provides a total score ranging from 0 to 30, with the lower scores indicative of more severe cognitive impairment. Scores < 25 were considered indicative of dementia (Vertesi et al. 2001). Whether participants needed a wheelchair for mobility (yes or no) also was collected. Finally, history of past involvement with horses (yes or no) was determined based on telephone interviews with the participants' primary caregivers.

A detailed description of the sample is presented in Table 2. The male to female ratio of the study population was approximately 1:1; however, the ethnicity of the population was predominately African American. Review of the participants' medical records indicated that seven different classes of medications that can affect cortisol levels were prescribed, with the majority receiving cholinesterase inhibitors. Roughly a third of the participants relied on wheelchairs for mobility. Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) scores suggested that participants needed some hands-on assistance with ADLs such as bathing, walking, and eating, and significant hands-on assistance with IADLs such as grocery shopping, cleaning, and paying bills. The mean MMSE score was 20.8, with a range of 11–28. One participant had a MMSE score above the expected 25 or lower score for this population. However, the participant's medical record did confirm a diagnosis of Alzheimer's disease. The MMSE scores for each of the two ADS residential groups were evaluated by a random-effects linear regression analysis. The MMSE scores were 7.14 units higher in residents of the Glen ADS group when compared with those of the Meadow residents ($p = 0.002$). Questioning of the caregivers regarding the participants' previous interactions with horses revealed that approximately 63% of the study population had experience with horses.

Procedures

To ensure validity and reliability of observational recordings, the principal investigators trained the research assistants in recording the behavior and affect of participants during the intervention. Training included written definitions and discussion of the affective characteristics of pleasure, interest, neutral, anxiety/fear, anger, and sadness as defined by the Philadelphia

Table 1. Characteristics of the horses used in the study.

Horse Name	Age (years)	Sex	Breed
Cactus Jack	12	Gelding	Paint
Shortie	19	Gelding	Quarter Horse
Wylan	14	Gelding	Quarter Horse
Grace	22	Mare	Pony

Table 2. Characteristics of the people in the study.

	Program Name			
Characteristic	Glen (n = 7)	Meadow (n = 9)	Total	p*
Female	6 (85.7%)	3 (33.3%)	9 (56.3%)	0.060
Ethnicity				
White	1 (14.3%)	2 (22.2%)	3 (18.8%)	> 0.99
Black	6 (85.7%)	7 (77.8%)	13 (81.2%)	
NMDA Receptor Antagonists, Yes	3 (42.9%)	3 (33.3%)	6 (37.5%)	> 0.99
Cholinesterase Inhibitors, Yes	5 (71.4%)	7 (77.8%)	12 (75.0%)	> 0.99
Antidepressants, Yes	2 (28.6%)	6 (66.7%)	8 (50.0%)	0.315
Anticonvulsants, Yes	1 (14.3%)	1 (11.1%)	2 (12.5%)	> 0.99
Chemotherapeutics, Yes	2 (28.6%)	0 (0.0%)	2 (12.5%)	0.176
Antipsychotics, Yes	1 (14.3%)	2 (22.2%)	3 (18.8%)	> 0.99
Steroids, Yes	1 (14.3%)	0 (0.0%)	1 (6.3%)	0.437
Experience with Horses, Yes	4 (57.1%)	6 (66.7%)	10 (62.5%)	> 0.99
	Mean ± *SD* (Min–Max)			
Age	73.8 ± 10.1 (56.4–83.0)	81.6 ± 8.5 (72.6–96.2)	78.1 ± 9.8 (56.4–6.2)	0.315
MMSE	24.0 ± 3.0 (20.0–28.0)	18.0 ± 4.7 (11.0–25.0)	20.8 ± 5.0 (11–28)	0.034
Percent ADL	4.8 ± 8.0 (0.0–22.2)	9.3 ± 8.4 (0.0–27.8)	7.3 ± 8.3 (0.0–27.8)	0.095
Percent IADL	49.5 ± 28.2 (9.1–91.7)	77.2 ± 13.9 (55.6–100.0)	65.1 ± 25.0 (9.1–100.0)	0.034

*Based on Fisher's exact test of association for binary variables and the non-parametric Wilcoxson rank-sum test for continuous variables.

MMSE = Mini Mental State Examination; ADL = Activities of Daily Living; IADL = Instrumental Activities of Daily Living.

Geriatric Center (PGC) Affect Rating Scale (Lawton, Van Haitsma and Klapper 1996). For example, pleasure included smiling, laughing, stroking, touching with "approach" manner, nodding, singing, arm or hand outreaching, open-arm gesturing, and eye crinkling. Research assistants practiced recording observations in a public setting, and compared their responses to establish inter-rater reliability, as well as at the ADS setting to allow assistants to utilize the recording instrument with the sample population. In addition, after each intervention session at the farm, observers debriefed on how they recorded the primary talking or touching behaviors including items related to the activity, horse, staff, or nothing, to ensure consistency.

Physiological and behavioral outcomes of interest were assessed prior to the intervention, weekly before and after engagement with horses or activities as usual, and after the intervention period using the following measures: salivary cortisol levels and a modified version of the Nursing Home Behavior Problem Scale (NHBPS).

Four therapy horses aged from 12 to 22 years were designated for the intervention activities (Table 1). Therapy horses needed to demonstrate the following for use in this study: 1) excellent ground manners, 2) no foot movement when startled, 3) history of being nonreactive to unusual stimuli including, but not limited to, wheelchairs and walkers, 4) toleration of loud noise, and 5) no startling with large arm gestures or rapid movement. The therapy horses used in this study were also used in therapeutic riding programs for autistic children and teenagers with behavioral and mood disorders.

Research and ADS staff attended an initial training session with the equine assisted-learning certified and horse-handler staff at an equine education center prior to the initiation of the intervention program. Training included horse safety and working with individuals with dementia. The equine-assisted therapy intervention program occurred once a week on the same day for four weeks and consisted of three specific intervention activities. At each weekly visit, activities experienced on the first visit remained the same as did the horses at each activity station. Activities were repeated in the same sequence at each consecutive visit. Each activity was a 15-minute hands-on experience with the horse followed by 5 minutes of rotation to the next activity. All interventions were ground-work only. Activity groups had two or three members who remained in the same group for the duration of the study. One ADS staff person per activity group was available to assist participants with wheelchair mobility, standing, or walking. Additionally, each participant was aided by one equine assisted-learning staff to ensure safe engagement with the horse. A 10-minute demonstration of safety measures was given to the participants before the intervention sessions commenced. The guiding principle for the intervention was that the client controls his/her interaction with the horse.

Intervention: In the first activity session, the participant learned how to groom the horse. Specifically, this included rubbing, brushing, as well as combing and braiding the mane and tail. The second activity allowed observation of horse to horse interactions as well as allowing the participant to seek interaction with the horse. In this rotation, horses were turned loose in the indoor arena and participants were free to interact with them or watch the horses interact with each other. The participants were educated on horse anatomy and given an explanation of the use of a halter and how to place it on the horse. The clients were given the option of leading the horse around the arena and when finished, removing the halter. The participants also were given the opportunity to photograph the horses during this period.

The last activity session provided a brief explanation of how the American Indian protected his war horse by painting tribal symbols on the animal's body. Participants were asked to paint the horse with symbols reflective of their thoughts and feelings for the animal. Non-irritating, biodegradable finger paint was used. After all groups had rotated through the sessions, the equine handler held the "painted" horse while all of the participants took turns washing the horse. The program ended with all of the participants offering the horses buckets of hay cubes as a "thank you" for their participation.

Two trained observers recorded each participant's behavior and affect every 30 seconds throughout each of 15-minute periods allowed for the grooming and painting intervention activities only. As is the ADS center's protocol with all activity programming, if the participant

became agitated, fearful, or anxious, they would be taken away from the horse by direct care staff.

Behavioral Observation Recording: Two trained research observers made recordings of participant behavior and affect every 30 seconds during the 15-minute intervention at two of the stations: grooming and painting. Observations were not taken at the third station in the indoor arena because activities varied from week to week and by individual physical abilities. Observers recorded whether participants talked or touched a) nothing, b) things related to the activity (halter, brush, comb, mane and tail clips, or bands and paint), c) horse, d) staff, or e) other participants. At the same time, they recorded the participants' affect by using a modified PCG Affect Rating Scale including recording expressions of pleasure, interest, neutral, anxiety/fear, anger, or sadness. The PGC Affect Rating Scale has been found to have high reliability among nursing home residents with AD, and measures of positive and negative affect were affirmed against other measures (Lawton, Van Haitsma and Klapper 1996).

Salivary Cortisol: Salivary cortisol levels were used as an indicator of physiological stress. Individuals diagnosed with AD can have alterations in the hypothalamic-pituitary adrenal axis resulting in prolonged hypercortisolemia, which may contribute to the underlying pathophysiology of AD. Studies consistently report high correlations between serum and saliva cortisol, indicating that salivary cortisol levels reliably estimate serum cortisol concentrations (Hiramatsu 1981; Vining et al. 1983; Francis et al. 1987). Pre-intervention baseline salivary cortisol samples were collected at two time points (11:30 am and 1:30 pm) from all participants at the ADS center one week prior to the scheduled four intervention sessions. The baseline cortisol samples were collected on the same week day and at the same times as scheduled for the cortisol sample collection during the intervention. Participants had salivary samples taken shortly after arriving at the equine therapy center (11:30 am) and then immediately after they had participated in the intervention sessions (1:00 pm). Once the intervention commenced, participants who were in the ADS center cross-over phase of the study had two salivary samples taken at times close to the scheduled times for the participants in equine-assisted therapy. The afternoon sample at the day center was adjusted to occur at 1:30 pm instead of 1:00 pm to accommodate a scheduled snack, thus preventing contaminating substances in the saliva from interfering with the immunoassay. The 30-minute difference in salivary cortisol collection between the two groups would not interfere with the mean diurnal cortisol pattern decrease for the elderly population during the day (Heaney, Phillips and Carroll 2010).

Care was taken when collecting saliva to avoid collection immediately after mouth cleaning, meals, snacks, or medications. In order to ensure validity and reliability for the cortisol measures, the principal investigators trained the research staff in saliva collection and labeling. The following protocol was used: (1) an explanation of the procedure was given to the participant; (2) the participant was asked to open his/her mouth; (3) the assistant placed a small inert polymer swab (Salimetrics® Children Swab P/N5001.06) under the tongue of the participant with a gloved hand; (4) the participant was asked to allow the saliva to pool and collect on the cotton under his/her tongue for a minimum of 60 seconds; (5) research assistants remained with the participant during the entire procedure. If signs of gagging were observed or if the participant fell asleep, the swab was removed immediately; (6) the swab was removed from the participant's mouth and placed in a clean pre-labeled (Salimetrics® Bar-coded Labels P/N 5007.00) swab storage tube (Salimetrics® Swab Storage Tube P/N5001.05); (7) the sample was dated and the exact time of collection recorded; and (8) the collection tube was placed

in a cooler with ice packs and transported to the analytical laboratory within two hours of collection. The samples were centrifuged at 4°C, aliquotted into eppendorf tubes, and immediately stored at -80° C. Samples from all participants at all time points were assayed for salivary cortisol at the same time using Salimetrics® High Sensitivity Salivary Cortisol Enzyme Immunoassay (EIA) kit (Salimetrics®, LLC, State College, PA USA), approved for use by the Food and Drug Administration as a diagnostic measure of adrenal function. The kit was used according to the manufacturer's protocol. The range of detectable salivary cortisol concentrations were 0.003 to 3.0 µg/dL while using 25 µl of saliva per test. If the sample volume was < 25 µl, the sample was diluted 2–5 fold. All reported values take the dilution into account. Study samples were assayed in duplicate. The inter-assay precision as reported by the variability coefficient of variation (CV) was 6.41% across 12 separate runs. The intra-assay variability CV was 3.65% across 14 replicates. Normal ranges for salivary cortisol concentrations in µg/dL are as follows: morning — adult females, ages 51–70 (0.149–0.739); adult males 51–70 (0.112–0.812); and afternoon — adult females, ages 51–70 (0.022–0.254); adult males 51–70 (< 0.004–0.228) (Aardal and Holm 1995). Normal ranges of salivary cortisol concentrations in µg/dL for the separate sexes of elderly adults are not specified in the published literature. However, salivary cortisol concentration ranges reported for combined sexes between the ages of 79 and 95 in the mid-morning (10:00 am) are 0.13–0.59 µg/dL, and for mid-afternoon (2:00 pm) 0.070–0.53 µg/dL (Hodgson et al. 2004).

Modified Nursing Home Behavior Problem Scale (NHBPS): The NHBPS is an inventory of 29 behavioral problems encountered in care facilities (Ray et al. 1992). Each behavior, such as resists care, becomes upset or loses temper easily, and fidgets, is scored on a Likert scale ranging from 0 (Never) to 4 (Always). Inter-rater reliability ranges from 0.754 to 0.827 in nursing homes and is highly correlated with other behavioral scales including the Nurses' Observation Scale for Inpatient Evaluation (NOSIE) (–0.747) and the Cohen-Mansfield Agitation Inventory (CMAI) (0.911). On a weekly basis, day center staff completed a modified version of the NHBPS at pre-test, immediately following the intervention, and at post-test. The scale was modified to include questions that were relevant to an adult day population. The final scale included 22 items (range of scores = 0–88).

Statistical Analysis

Participant characteristics are presented as frequencies and percentages for categorical variables, while continuous variables are presented as means, standard deviations, and the range (minimum to maximum). NHPBS scores are presented as means and standard deviations over day, period, and treatment (intervention [farm] vs. comparison group [center]). A random-effects linear regression model was used to establish the relationship between NHBPS scores and study parameters in this cross-over design. The model included terms for treatment (farm vs. center), time (a one day increase in the days of participation), time of day (end of day vs. 11:30 am), sequence (farm to center vs. center to farm), community program (Meadow vs. Glen), period (second vs. first), and an interaction variable for community program and period. The initial modeling process included gender of the participant; however, its p value was 0.868 and was thus removed from the model. Similarly, age was removed from the model as its p value was 0.190.

A random-effects linear regression model estimates random slopes and intercepts for each individual in the model and then estimates an overall effect for the various terms in the model. Thus, slopes were estimated directly from linear contrast statements after fitting the model. The data collected in this study tended to be highly variable, and so it is common for the standard

deviation to be larger than the mean. Using this approach, we estimated the effects on an individual basis or on a group basis (a specific term in the model such as program). The latter is reported in the results as this was the aim of our study. The reported slopes are the change in the NHBPS score per day and were estimated directly from the regression model. Random-effects linear regression was used since the cross-over design has repeated measures nested within a participant and thus allows for the within- and between-participant variability along with an unstructured correlation when estimating the standard error used to test regression coefficients. All analyses were run using Stata 12.0 (Stata Corporation, College Station, TX, USA).

Results

Effects of the Intervention on Behavior and Affect of Participants

To evaluate the participants' experiences with equine-assisted therapy, the mean percent of time a particular affect (pleasure, interest, neutral, anxiety, anger, sadness) and behavior (talking or touching nothing, things associated with the activity, the horse, staff or other participants) for the grooming and painting activities were calculated, along with the slope and p values for the mean scores across the four intervention days. One participant became fearful and agitated and expressed fear of the horses during the first week of the intervention. This client returned the following week and engaged in activities the remaining three weeks. No clear pattern of affect or engagement over the four-day intervention was found, as one-third of the participants' time was spent expressing pleasure (31.4–46.1%) or interest (37.5–46.7%) during painting and grooming sessions (pleasure = 31.8–38.7%; interest = 37.5–43.9%). The majority of participants' time was spent interacting with things (35.3–69.5%), the horse (48.4–67.7%), or staff (68.7–81.7%) during the grooming activities. Participants engaged positively in the activities beginning week one and the following three weeks of the intervention. Of note, was a significant decrease in touching things (slope = –5.8; $p = 0.047$) and the horse (slope = –5.9; $p = 0.004$) during painting activities over time. This finding is consistent with the qualitative comments made by participants in the last two intervention sessions, questioning the purpose of the painting and how the horse feels about being painted.

Effects of the Intervention on Salivary Cortisol Concentrations

As a measure of stress, within-person mean daily cortisol values were calculated within the day and across each time period and then pooled across all participants within the group, providing a gross estimate of salivary cortisol concentrations for each group. No salivary samples had to be discarded due to participant choking, gagging, or falling asleep. Using linear contrast statements to estimate the treatment effect of the equine-assisted therapy vs. ADS as usual for the groups, the group with the higher mean MMSE scores had a statistically significant increase in cortisol levels when attending the farm intervention compared with when they participated in ADS ($p = 0.006$). However, the group with the lower mean MMSE scores had decreased cortisol levels (by 0.022 µg/dL) at the farm intervention compared with activities as usual at ADS, although this was not statistically significant ($p = 0.304$). When considering salivary cortisol levels at the farm intervention site only, the center group with the higher MMSEs had a statistically significant overall increase in cortisol levels compared with the overall cortisol levels of the center group with lower MMSE scores, ($p = 0.030$). However, when the clients were at ADS, there was no difference in cortisol levels between the two groups ($p = 0.999$). No overall changes in cortisol levels could be found when considering the sequence of participation in the farm intervention vs. ADS or the number of visits to either place.

Table 3. Mean Nursing Home Behavior Problem Scale scores.

Treatment	Time	Day 1		Day 2		Day 3		Day 4	
		Mean	*SD*	Mean	*SD*	Mean	*SD*	Mean	*SD*
Period 1									
Intervention	11:30 am	3.50	4.81	2.00	2.00	0.50	0.76	1.00	1.07
	End of day	3.50	8.00	1.00	1.60	1.13	1.55	0.50	0.93
Comparison	11:30 am	6.75	6.41	5.88	4.29	4.25	3.45	4.00	3.55
	End of day	4.25	4.62	4.50	2.39	3.88	3.00	3.75	3.37
Period 2									
Intervention	11:30 am	2.38	2.20	2.50	2.20	2.13	3.48	–	–
	End of day	0.88	1.36	1.38	2.20	1.50	2.83	–	–
Comparison	11:30 am	0.88	1.13	2.50	3.46	0.25	0.71	–	–
	End of day	0.88	1.13	2.88	3.27	0.25	0.71	–	–

Table 4. Results from the random-effects linear regression analysis.

Variable	Coefficient	95% CI		*p*
Treatment: Farm vs. Center	–1.11	–1.67	–0.55	< 0.001
Day, One Unit Increase	–0.62	–1.05	–0.20	0.004
End of Day vs. 11:30 am	–0.52	–1.07	0.04	0.067
Sequence: Farm/Center vs. Center/Farm	1.71	0.38	3.03	0.012
Program: Meadow vs. Glen	2.49	1.04	3.94	0.001
Period: Second vs. First	–0.18	–1.01	0.66	0.679
Program × Period Interaction	–3.24	–4.36	–2.12	< 0.001
Constant	3.27	1.38	5.16	0.001
First Period: Meadow vs. Glen	2.49	1.04	3.94	0.001
Second Period: Meadow vs. Glen	–0.75	–2.20	0.70	0.310

The salivary cortisol profiles of the participants followed the natural diurnal cortisol rhythm by decreasing in the afternoon compared with the morning throughout the evaluated time period. The time effect (afternoon vs. morning) showed a decrease of 0.008 units in cortisol in the afternoon compared with the morning; however, the result is not statistically significant ($p = 0.555$). For each one-year increase in age, the cortisol concentration increased by 0.003 units, but this result did not obtain significance at the 0.05 level ($p = 0.068$). Our statistical model controlled for seven classes of medications that were prescribed to the clients and were known to affect cortisol levels (Table 2). Only antidepressant use decreased cortisol levels in this study population and this result was not statistically significant ($p = 0.264$).

Effects of the Intervention on Disruptive Behaviors Displayed at the Adult Services Day Center

The pre and post within- and between-group mean scores for the NHBPS were calculated and are presented in Table 3. Period one represents the first intervention period and period two includes the cross-over intervention period. Mean scores for day four in the second period are not

reported because the data were erroneously not collected by program staff. Regardless of the test period, the overall mean number of problem behaviors tended to decrease after the visit to the farm. The pre-test scores on the farm days compared with the ADS days were also lower, suggesting that fewer behavior problems were present with the anticipation of interacting with the horses.

The results of the random-effects linear regression analysis are presented in Table 4. The NHBP scores for the intervention group were 1.11 points lower than the comparison group ($p < 0.001$) and this result is independent of the day (no interaction between treatment and day), suggesting that the AAT with horses has a positive impact on problematic behaviors commonly experienced by individuals with dementia. Regardless of whether the participants were in the treatment or control group, on average their NHBP scores dropped by 0.62 across each week ($p = 0.004$). Despite random assignment, there was a significant interaction between period and program. During the first period, the NHBP scores were 2.49 points higher in the Meadow program (limited functioning) compared with the Glen program (higher functioning) ($p = 0.001$). During the second period, the NHBPS scores were 0.75 points lower in the Meadow program compared with the Glen; however, the result was not significant ($p = 0.310$).

Discussion

This exploratory study developed and tested the impact of equine-assisted therapy for individuals with AD. Participants were able to positively engage in activities such as grooming, painting, and leading the horses. Our findings suggest engagement in equine-assisted therapy may reduce problematic behaviors that can be exhibited by individuals with AD attending ADS centers. Problematic behaviors such as wandering and resisting care exhibited by individuals with AD can be very stressful for formal and informal caregivers. In fact, individuals who are caring for persons with AD experience the highest levels of strain and mental and physical health complications compared with caregivers of individuals without dementia (Ory et al. 1999). Enrollment of an individual with AD in an ADS that provides equine-assisted therapy may offer an opportunity to temporarily relieve caregivers from problematic behaviors in formal care environments and at home.

When speculating about the nature of the process that could be impacting this behavior change in the participants, it could be that animals have particularities that may trigger interest and stimulate sensory functions: they convey multisensory stimulation through sounds, postures, smell, and touch, and they may be actively demanding in the interaction (Redefer and Goodman 1989). However, these benefits can be experienced through AAT with dogs and cats in ADS centers. So why horses? Recent research confirms the importance that enriched environments play in human neurobiological development (Affum et al. 2010). Furthermore, Bredy et al. (2003) found a partial reversal in delayed cognitive function through the use of environmental enrichment. Therefore, as suggested by Marino (2012), the impact could be the result of an enriched environment such as the barn with a woods environment used in this study. This provided a surrounding that was complex, facilitated learning, and was socially stimulating, and therefore was not reliant on a single factor such as the horse, but rather a combination and interaction of several factors that appeared to stimulate change. The participants often mentioned how relaxing it was to come to the "country" to spend time with the horses and eat lunch under large shade trees with no apparent noises of the city. This enriched environment is not available when a therapy pet such as a dog or other small mammal is brought into the existing care center.

On a practical level, can this equine-assisted therapy, when compared with other AATs, be shown to be effective enough to justify the expense and other practical considerations of instituting such a program? This question can only be answered by designing blinded, crossover studies to determine how much more benefit an elderly population with AD derives from AAT with companion animals (dogs, cats) in routine care settings compared with those obtained through equine-assisted therapy in an enriched environment. Currently, these studies do not exist.

Contrary to our expectation that equine AAT would lower salivary cortisol in both groups with AD, higher salivary cortisol levels were found in the AD clients with higher MMSE values during the farm intervention period. The rise in cortisol subsequently decreased when they participated in ADS as usual. The salivary cortisol levels were used as a measure of stress. The term "stress" conjures up negative connotations that imply emotional and physiological pathology when inefficiently managed. Chronic stress in animal models causes atrophy of neurons in the hippocampus and prefrontal cortex, brain regions involved in memory, selective attention, and executive function, but causes hypertrophy of neurons in the amygdale, a brain region involved in fear, anxiety, and aggression (McEwen and Chattarji 2004). Sustained increases in cortisol concentrations represent a biomarker for chronic stress. Conversely, "good stress" in popular vernacular refers to those experiences that are of limited duration and that a person can master, which ultimately leaves a sense of exhilaration or accomplishment and does not cause physiological damage (McEwen 2007). The observation of the temporary increase in cortisol levels in this AD group during the intervention possibly represents a biomarker for good stress. The premise of good stress relies on the mechanism of action of stress hormones, particularly cortisol. Good stress within the context of a learning experience induces focused attention and improves memory of relevant information (Joels et al. 2006). Behavioral evidence for cortisol in this group as an indicator of "good stress" is reflected in the statistically significant lower modified NHBPS scores found when the clients attended the intervention, as compared with the scores when they were at the ADS center.

An unexpected anecdotal observation in this study was the apparent role of equine AAT as a motivator to engage in physical activity. The participants in this study had moderate limitations to standing or rising unassisted and ambulating; however, when presented with the therapy animal, several of the clients rose without assistance, offered to try and walk the horses unassisted, and would ask for help to rise out of their wheelchair. Surprisingly, the ADS staff had not seen some of the clients ask to get out of their wheelchair or walk readily over steps or up ramps without assistance, all activities that they repeatedly demonstrated at the farm, with the frequency of these behaviors increasing at each successive session.

Risks associated with an equine-assisted therapy program for the elderly should be assessed for both the client and horse. The most common human risk is allergies comprising both skin and/or respiratory components. The medical records of our participants were thoroughly examined before enrollment, eliminating this as a potential reason for withdrawal from the study. Zoonotic risks (defined as "diseases and infections, which are naturally transmitted between vertebrate animals and humans"; World Health Organization) from horses to humans include, but are not limited to, the transmission of dermatophyte (fungal, "ringworm") or dermatophilosis, (bacterial) cutaneous infections. These infections are generally found in horses that inhabit filthy, moist, and crowded environments, but can also be spread rapidly by use of contaminated tack, saddle pads, and brushes, even in apparently healthy horses. Conversely,

horses can be at risk of acquiring methicillin-resistant *Staphylococcal aureus (S. aureus)* from human contact and vice versa. Methicillin-resistant *S. aureus* (MRSA) is an important hospital and community associated pathogen which causes infection in people with risk factors such as recent hospitalization, surgery, antibiotic use, chronic illness, and residence in long-term care facilities. Horses are at higher risk of developing infection if they become sick, injured, or stressed for another reason, such as when they are admitted to an equine hospital. Horses can acquire MRSA from people and other horses. In colonized horses, MRSA is most often carried in the nose, so direct hand-to-nose contact between people and horses and nose-to-nose contact between horses are probably important routes of transmission (Weese 2011). Precautions to reduce the risk of transmission for both the horse and participant during therapy sessions should be to advise frequent washing of the hands or use of an alcohol-based hand sanitizer. Although these precautions are advised, it is impossible to completely prevent horses (or people) from being exposed to MRSA because so many people and animals carry it without any signs.

Future studies should investigate if the behavior changes exhibited at the ADS centers are recapitulated in the home environment. Additionally, research is needed to examine process-oriented measures to determine which elements of the equine-assisted therapy experience are beneficial and for which kind of participant. Specifically, additional studies need to address: 1) whether enough bonding is achieved through occasional encounters, 2) how the interaction works: modalities involved, active or passive presence, intentional cues, and 3) whether "a third party" should interfere, such as an ADS staff person, or whether the horses and humans should interact freely? It is reasonable to postulate that inter-individual variability is high and that species, situations, and modalities may have to differ according to the level of dementia.

Limitations

This exploratory study had several limitations. First, participants were not randomly selected. This may have resulted in a degree of selection bias, with those older adults who were most interested and capable choosing to participate in the study. Despite efforts to ensure reliability and validity of measures, there were risks of bias in the observational and behavioral measures. Research assistants and staff were not blind to who was receiving the treatment. In addition, participants may have received different experiences with the horses depending on the particular staff who worked with them during the intervention activities, and intervention activities could have varied by group and by individual. Despite these concerns, we do believe this study provides an important first step to exploring equine-assisted therapy for persons with AD.

Conclusion

Equine-assisted therapy is a feasible, non-pharmacological intervention to reduce problematic behaviors among people with AD, resulting in easier caregiving for formal and informal carers. This therapy may provide a tailored intervention that can positively impact the quality of life of the person living with AD and their caregivers. Future studies should include selection indicators, additional process measures, and additional outcome measures such as quality of life and mood.

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Effects of a Form of Equine-Facilitated Learning on Heart Rate Variability, Immune Function, and Self-Esteem in Older Adults

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Effects of a Form of Equine-Facilitated Learning on Heart Rate Variability, Immune Function, and Self-Esteem in Older Adults

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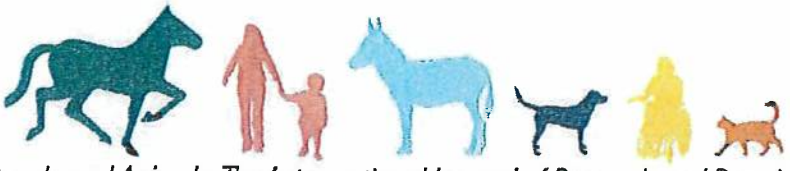

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Effects of a Form of Equine-Facilitated Learning on Heart Rate Variability, Immune Function, and Self-Esteem in Older Adults

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Keywords: horse-human interaction, equine-facilitated learning, heart rate variability, self-esteem, immune function

Abstract Equine-facilitated learning (EFL) helps people access their immediate sensations and feelings because horses, as prey animals, are continually aware of their environment and provide instant feedback to human behaviors and emotions. We hypothesize that during EFL, older people become more aware of their bodily sensations and emotions, leading to increased heart rate variability (HRV), improved self-esteem (Rosenberg scale), and improved immune function. Twenty-four subjects (age > 55) participated in a single 15-minute EFL activity, *Con Su Permiso,* during which they focused on their bodily sensations and the responses of the horse as they moved toward and around the horse. Subjects served as their own control, interacting with a human. Pre and post measures of HRV were obtained from humans and horses; self-esteem score and immune response (salivary immunoglobulin A, sIgA) from humans. During equine and control interactions, the subject's HRV (and the horse's when present) was monitored, while being synchronized with a video recording. An exit interview was conducted after each interaction. Words and gestures relating to feelings and sensations were categorized as positive, neutral, or negative. Human heart and respiration rates as well as HRV (SDRR) increased significantly during interactions with horses and humans compared to baseline (paired *t*-test, $p < 0.05$). During equine interactions, human HRV frequency spectrum shifted somewhat to the very low frequency (VLF) range ($p < 0.05$). The four horses' HR and HRV responses were varied, but in all cases HRV frequency peaks were predominantly in the VLF range. Human self-esteem increased during interactions with horses and humans ($p < 0.05$) but sIgA did not change. During exit interviews participants used more positive and fewer negative gestures ($p < 0.05$) describing the equine experience compared to control; words and gestures were more consistent with each other. These findings mostly support our hypothesis and suggest that engaging with horses benefits humans, indicating an enlivened state without stress.

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Introduction

According to the Professional Association of Therapeutic Horsemanship International, equine-assisted learning (EAL) is an experiential learning approach that promotes the development of life skills for educational, professional, and personal goals through equine-assisted activities. A more precise nomenclature for EAL is equine-facilitated learning (EFL). Although EFL appears to benefit people physiologically and psychologically (McCormick & McCormick, 1997), only a few quantitative, peer-reviewed physiological data studies are available. For example, EFL reduced symptoms of anxiety and PTSD in participants who had experienced a trauma (Earles, Vernon, & Yetz, 2015). Little is known about the causal effects of EFL on human well-being, but there is evidence that EFL can reduce salivary cortisol concentrations in children (Pendry, Smith, & Roeter, 2014), indicating that EFL decreases stimulation of the hypothalamus-pituitary-adrenal axis. In support of this hypothesis, experienced riders, riding horses along a predetermined course, demonstrated a shift in their autonomic nervous balance toward parasympathetic dominance (Matsuura et al., 2017). However, it is still not known whether unmounted activities, such as EFL, have a similar effect on the autonomic nervous system.

Adults in mid- to late life are particularly prone to physiological and psychological disorders related to autonomic imbalance, such as hypertension, cardiovascular disease, immune dysfunction, anxiety, depression, and low self-esteem. Heart disease remains the leading killer of adults over age 65 (Centers for Disease Control and Prevention, 2016) and 15%–20% of Americans over age 65 have experienced depression. Depression is physiologically linked to stress; changes in the serotonin and stress hormone systems produced by sustained stress mimic to a substantial extent the disturbances in these systems that may be observed in depression (van Praag, 2005). Depression is a threat to senior health that can lower immunity and compromise a person's ability to fight infections (American Psychological Association, n.d.). Chronic autonomic imbalance in favor of the sympathetic system may play an important role in the processes of atherosclerosis (Sajadieh et al., 2004; Sroka, 2004), hypertension (Grassi, 2015), immune dysfunction (Segerstrom & Miller, 2004), and depression (Wang et al., 2013). In addition, a substantial body of literature suggests a link between self-esteem and cardiac vagal autonomic tone (Martens, Greenberg, & Allen, 2008). Therefore, if EFL could promote autonomic balance, older people would benefit greatly.

A well-established biomarker of autoregulation is heart rate variability (HRV). Higher variability indicates improved cardiovascular function (Soares-Miranda et al., 2014), emotional health (McCraty, Atkinson, Tiller, Rein, & Watkins, 1995; Segerstrom & Nes 2007; Traina, Cataldo, Galullo, & Russo, 2011), and social engagement (Porges, 2003), while a low HRV is associated with depression and even panic disorder (Porges, 2003). Heart rate variability is increased by body awareness therapy, in which participants focus on their sensations and emotions, moment by moment, during simple exercises such as sitting and standing (Mantovani et al., 2016). During some forms of EFL, trained facilitators also encourage clients to focus on their own bodily sensations in an effort to access their current emotional and mental states. *Con Su Permiso* is one such type of EFL exercise in which participants are asked to observe feelings and sensations in their body that arise from focusing on the horse. For this reason, *Con Su Permiso* was the EFL activity chosen for this study.

The following hypothesis was proposed: During EFL with horses (*Con Su Permiso*), older people become more aware of their bodily sensations and emotions, leading to increased HRV and improved immune function and self-esteem. These three measures are biomarkers for health.

Since EFL involves horses as well as people, it is important for the success and integrity of the whole process that the horses themselves are not stressed. Horses are social animals and respond to external stimuli that may go unnoticed by the facilitators or handlers, resulting in increased stress. In horses and humans HRV is a sensitive, reliable indicator of fear or anxiety, and the HRV frequencies of horses fall

within the same ranges as those of humans (Gehrke, Schlitz, & Baldwin, 2011). Therefore, this biomarker was selected for horses and humans to evaluate stress levels before, during, and after *Con Su Permiso*. Pilot studies (Gehrke, 2010), in which HRV was measured simultaneously in horses and humans during EFL activity, showed higher than expected cross correlation coefficients between the paired measurements, suggesting some degree of synchronicity between heart rhythms.

Few studies have reported the responses of horses to EFL. Previous investigators simultaneously monitored the heart rates of horses and at-risk youth during EFL, but the study was too poorly designed to yield meaningful data (Drinkhouse, Birmingham, Fillman, & Jedlicka, 2012). Other studies suggest that psychological stress in humans may influence horse heart rate and behavior (Keeling, Jonare, & Lanneborn, 2009; Merkies et al., 2014).

This is the first study to record HRV data simultaneously from horses and humans to determine how EFL affects HRV in older human subjects without diagnosed disabilities. The data obtained will provide a baseline with which to compare results from future studies involving people with issues such as PTSD, autism, and dementia. This study is part of a long-term project to provide an objective basis for designing effective, safe, and mutually beneficial EFL programs.

Research Questions

1. When participating in EFL with horses (*Con Su Permiso*), do older people become more aware of their bodily sensations and emotions, leading to increased HRV and improved immune function and self-esteem?
2. Is HRV an effective biomarker for emotional stress in horses employed in EFL, and does it provide some insight into their suitability for EFL in terms of whether or not it benefits them physiologically?
3. Does participation of horse-human pairs in *Con Su Permiso* cause synchronistic changes in HRV?

Materials and Methods

In this study, HRV was measured in older people before, during, and after participating in *Con Su Permiso*, and pre and post measures of immune function and self-esteem were obtained. The same participants also performed a sham version of the EFL exercise in the same place in which a human volunteer substituted for the horse. During each activity participants were instructed to pay attention to the horse's responses and to focus on sensations they felt in the palms of the hands. Afterwards, in their exit interview, they were asked to describe the feelings or sensations they experienced.

Studies were performed over three weekends in October/November 2014 with 24 adults aged 55+ (19 F, 5 M) at Borderlands Center for Equine Assisted Services, Sonoita, Arizona. (Note: The term "Equine Assisted" includes EFL). The experimental protocol was approved by the University of Arizona Human Subjects Protection Review Board and the Institutional Animal Care and Use Committee. The number of subjects was chosen by performing a power analysis on preliminary data comparing HRV before and after a meditation exercise for another study in which 30 participants (aged 30–69) focused on sensations in the palms of their hands, similar to *Con Su Permiso*. Power was estimated assuming standard α values (95% confidence limits or $\alpha = 0.05$). The calculated power for $n = 20$ was 0.87 and was above the sufficient statistical power of 0.8. Therefore, using $n = 24$ would ensure that the data obtained were statistically meaningful. To further account for attrition, four additional people were recruited as "backups" in case any of the 24 recruits were unable to participate on the day.

Participants

Humans

Participants were recruited from the investigators' business associates in Arizona.

Inclusion criteria for human participants were as follows:

1. Age 55 or older;
2. Able to stand and walk on uneven ground for 30 minutes;
3. Have no known cardiac arrhythmias;
4. No metal plates, pacemakers, or similar devices in the body to prevent possible interference with heart rate monitors;
5. Not currently riding or owning a horse but previous horse experience is permissible.

The Adventures in Awareness release form, completed by all participants, requires a list of prescription medications. Fourteen participants were prescription-free, two took replacement hormones only, one used glaucoma eyedrops only, three took statins or blood pressure medicine only, one took dexamethasone, and three took antidepressants. None of the participants had pet allergies. On recruitment, the following instructions were given to the participants:

1. All participants were required to abstain from caffeine before testing and not to eat for one hour before testing began. Normal eating and drinking were allowed after measurements were completed.
2. On site, no interaction was allowed with the horses before the testing.

Horses

Serra June: Half Arab, Half Percheron, 32-year-old dark bay mare, 14.3 hands

Sum Punk: Half Arab, Half Curly Bashkir, 24-year-old red roan gelding, 14.1 hands

Brown: Quarter Horse, 22-year-old dark-brown gelding, 16 hands

Chance: Quarter Horse, 9 years old, chestnut gelding, 16 hands

The horses met the standards of health and treatment for Professional Association of Therapeutic Horsemanship (PATH) International, were active in EFL, and had been identified as being particularly willing to engage. The process included inviting the horses to volunteer prior to the arrival of the participants. The two facilitators spent time with the 10 available horses to determine which ones would approach. The four horses that came forward had also successfully participated in a small pilot study the previous year. Each of these four horses was given the opportunity to withdraw, if it chose, through the mutual choosing activity. Although some of the horses were aged, they were all actively ridden and regularly worked in EFL programs to provide them with healthy exercise and interactions with people, which they seemed to enjoy.

Procedures

Experimental versus Control Groups

Three groups of eight subjects each came for one of three consecutive weekends.

Four subjects came in the morning and four in the afternoon, both Saturday and Sunday. Half the subjects did the horse-human interaction the first day, followed by the same interaction but with another human substituting for the horse the second day. Half the subjects did the reverse order. Participants were randomly assigned to morning vs. afternoon sessions and horse first vs. human first. The horse interaction, *Con Su Permiso*, is a relationship-building interactive exercise with the horse based on the Adventures in Awareness invitational approach. Professional Association of Therapeutic Horsemanship standards and guidelines were followed in all applicable situations including those related to mental health.

Overall Protocol

1. Participants were greeted inside the house where release and IRB forms were signed and consent was given. They were informed that they were free to stop participating in the activity at any point if they wished. Four baseline measurements were taken: HRV, respiration (both for 5 minutes), self-esteem (Rosenberg scale), and saliva sample for sIgA.
2. At the same time, baseline HRV measurements were made for 5 minutes on each of the four horses assigned to the experiment.
3. Subjects watched one video on safe behavior around horses, and another showing one

of the facilitators explaining *Con Su Permiso.* Participants were told they were going to approach the horse, accompanied by a facilitator, closely observing how the horse responded, and at the same time focusing on sensations they might feel in the palms of their hands. When they were close to the horse, they would use their palms to scan around the shape of the horse's body, keeping their hands 3–5 inches away from the body surface.

4. Participants practiced sensing feelings in their palms by rubbing their hands together, moving their hands apart, and gradually bringing the palms of the hands together. While doing this, they were encouraged to breathe more slowly and deeply than usual.
5. Subjects were escorted outside for Mutual Choosing (selection of horse, taking into account horse's preference) before the *Con Su Permiso* interaction.
6. Subjects chose between two trained facilitators, A or B.
7. One by one, participants performed *Con Su Permiso* with the horse in the presence of the facilitator of their choice. HRV measurements were made simultaneously on horse and human, synchronized with video recording of the activity.
8. Upon completion of *Con Su Permiso,* each subject participated in a three-question exit interview, which was video recorded. The questions asked were:
   i. What did you sense or feel during *Con Su Permiso*?
   ii. When did you feel it?
   iii. Is there anything else you would like to share?
9. Participants returned to the house for post-measurements (Self-Esteem and saliva sample).
10. At the same time post-HRV measurements were made on each of the horses for 5 minutes.

Due to the logistics of working with groups, the time between baseline HRV and EFL HRV readings, and between EFL HRV and post-HRV readings varied from 60 to 100 minutes and from 20 to 50 minutes, respectively. On average, each participant spent about 15 minutes with the horse, but HRV was only recorded for the 4–5 minutes duration of the designated interaction. The time between pre- and postactivity HRV measures was the same for each participant.

Details of Horse-Human Interactions

Mutual Choosing

Participants paid close attention to the four selected horses in the turnout areas, noticing how each horse responded to them as they imagined sending the horse love and appreciation from their heart. The main factors governing the mutual choosing were: (1) the person's attraction to the horse, and (2) a corresponding interest expressed by the horse, for example, moving toward, looking at, or pointing ears toward the person. The size of the horse with respect to the rider was not relevant because *Con Su Permiso* is an unmounted activity.

Con Su Permiso (With Your Permission)

One by one, participants entered the experimental arena in which their selected horse was located and were reminded to breathe more deeply and slowly than usual; slow breathing is correlated with improved cognition (Chandla et al., 2013). They slowly approached the horse (held by a handler on a loose lead line) in the presence of the facilitator, holding their hand out toward the horse's nose, palm down, said "Hello," and returned to the edge of the turnout. Having rubbed their palms together to heighten sensation, they quietly approached the horse with palms open, under guidance from the facilitator. They moved closer when an invitation from the horse, such as looking or moving toward them, was perceived. Holding their palms 3 to 5 inches away from the horse's body, they scanned the shape of the horse's entire body with their palms, noting any sensations in their hands. Once the exercise was complete, they thanked the horse and returned to the starting point.

Control Activity

When participants experienced the control *Con Su Permiso*, they were told that the purpose of this activity was just to give them practice, or further experience, in detecting sensations in the palms of their hands and not to expect any response from the person. Then the subject was fitted with the HRV monitor while the horse substitute person (who did not wear a HRV monitor) entered the arena. Next the subject entered the arena and slowly approached the horse substitute person, who stood quietly and relaxed, breathing slowly, looking out to the horizon, and not paying any particular attention to the subject. The horse handler (the same one who was present at the subject's real *Con Su Permiso*) stood a few feet away from the horse substitute person with minimal movement or interaction. As subjects walked toward the horse substitute person, they held their palms 3 to 5 inches away from the person's body and scanned the shape of the body with their palms, noting any sensations in their hands. The control *Con Su Permiso* included all components of the real one except for the subject's reward of engagement with the horse. Similar to the interaction with the horse, participants spent about 15 minutes with the horse substitute person, but HRV was only recorded for 4–5 minutes.

Experimental Measures

Heart Rate Variability, the degree of change in heart rate over time, is measured as: (1) the standard deviation of the interbeat interval (SDRR) that reflects the size of the variation, and (2) the root mean square of successive differences (RMSSD), related to parasympathetic stimulation of the ANS. The frequency of the HRV oscillations is divided into three ranges: very low frequency (VLF: 0.003–0.04 Hz), an intrinsic rhythm of the heart; low frequency (LF: 0.05–0.15 Hz); and high frequency (HF: 0.15–0.4 Hz) (Task Force of the European Society of Cardiology, 1996). The LF power (or %LF), or strength of the LF oscillation, reflects both sympathetic and parasympathetic activities (usually mainly sympathetic), and the HF power (or %HF) reflects parasympathetic activity. As humans interacted with their selected horse using *Con Su Permiso*, we expected an increase in their SDRR and RMSSD as well as a high LF power centered on a frequency of about 0.1 Hz during the activity if they were breathing more slowly than normal (Vaschillo, Vaschillo, & Lehrer, 2006).

HRV and respiration were measured in humans using a Zephyr Bioharness BT. The harness was attached to each subject around the chest, and pulse data were recorded via a wireless Bluetooth connection, allowing the subject to move freely. Pulse measurements on horses were made using a Polar Equine RS800CX belt around the girth area for calculation of HRV.

When analyzing and comparing HRVs recorded during baseline and *Con Su Permiso*, the sampling duration of baseline HRV data was reduced to match that of the *Con Su Permiso* HRV data. To achieve a match, usually about 30 s of data were systematically deleted from each end of the baseline recording. All HRV measurements were manually corrected for artifacts (data points outside a range of two standard deviations from the mean).

Salivary Immunoglobulin A (sIgA) concentration (mg/dl) is a marker of immune function.

Salivary IgA is a class of antibodies that lines the intestine and airways and is an established marker of immune function (Tsujita & Morimoto, 1999). Research subjects who focused on positive emotions, such as care and compassion, for just 5 minutes showed significant increases in sIgA production (Rein, Atkinson, & McCraty, 1995). Participants who petted a dog for 18 minutes had increased salivary sIgA concentrations immediately after being with the dog compared to baseline (Charnetski, Riggers, & Brennan, 2004). No equivalent data are yet available for humans interacting with horses. In this study participants produced a saliva sample in a vial that was then immediately refrigerated. After the 2-day session was over, all the samples were express mailed to Diagnos-Techs Inc., Tukwila, Washington, for a nephelometric analysis.

Self-Esteem was measured using Rosenberg's Self-Esteem Scale (RSES; Rosenberg, Schooler, &

Schoenbach, 1989). The RSES scale has been used with a variety of groups including adults and is considered a reliable and valid quantitative tool for self-esteem assessment (Blascovich & Tomaka, 1993). Self-esteem is a powerful predictor of health and longevity (Lipschitz, 2007). Low self-esteem leads to stress and increases the risk of high blood pressure, heart disease, stroke, and cancer. Since older people are particularly susceptible to all these health problems, improvement in self-esteem would be particularly beneficial. Participants answered 10 questions related to their self-esteem in the moment on a 4-point scale (strongly agree, agree, disagree, strongly disagree) preactivity and postactivity. Responses were digitized and averaged to provide an indication of the effect of the activity of their self-esteem.

Exit Videos

Participants were interviewed by their facilitator, and the participants' answers to the three questions listed in item 8 of the Overall Protocol were recorded using a Sony HDR-CX240 video camera. The words and gestures used in exit interviews were quantitatively analyzed to assess the comparative emotional effects of equine and control *Con Su Permiso* on human participants. Analysis of exit interviews was an exploratory part of the study to determine whether further investigation in the future was justified. The analysis was performed at a basic level with one student analyzing the words and another student the gestures. Neither student had been present at the experimental data collection events; they were told that the purpose of the study was to compare people's reactions to humans and animals. The exit videos were transcribed, and any adjectives describing feelings, sensations, and emotions experienced during *Con Su Permiso* were highlighted. Gestures made by the participants during the interviews were systematically recorded. Both students were trained by a lead investigator to analyze words and gestures, and both practiced these activities in the presence of the investigator before collecting data. The first three exit videos were rated by both of the students for words and gestures to assess interrater reliability, and the results were almost identical, confirming the validity of the rating procedure.

Words

Any adjectives used to describe feelings or sensations were separated into groups based on whether they had a positive, neutral, or negative connotation. These connotations were decided based on several information sources (Chi, 1997; Common adjectives table, 2016; Pierce, 2011). Any words that did not appear in the published lists were placed as seen fit based on the unanimous agreement of three investigators. The total numbers of positive, neutral, and negative words were determined for each interview, and the averages and standard deviations were calculated for *Con Su Permiso* with horse and *Con Su Permiso* with substitute person.

Gestures

Facial expressions and bodily movements can indicate the way people are feeling, whether happy, nervous, or neutral. The nonverbal portion of the interview is important because interviewees may not be aware of how they feel or may not tell the full truth about what they are feeling. For this reason the gestures made by participants when describing their experiences were categorized into positive, negative, and neutral based on observations recorded in books and articles by psychologists ("Body language," 2008; Cherry, 2015; Furnham, 2015; Nierenberg & Calero, 2001; Pease & Pease, 2006; Skhiri & Cerrato, 2003; Weinschenk, 2012; Whitbourne, 2012). The gesture classification assembled for this study is shown in Table 1.

A higher number of positive words and gestures would indicate that the participant enjoyed the experience, whereas greater numbers of negative words and gestures would indicate the opposite. A high number of neutral words and gestures would indicate that the participant was indifferent toward the experience or unaware of its effects. After comparing the positive, neutral, and negative words and gestures, a congruence comparison was made between the participants' words and gestures. To perform this test, each type of word (positive, neutral, negative) was ranked from highest to lowest, based on the

Table 1 Classification of Gestures from Video Recordings

Positive	Neutral	Negative
Eye contact	Hands on ears	Fiddling
Lifts arms	Touches self	Clasps hands
Smiles	Touches something else	Furrows eyebrows
Palms open	Deep inhalation	Hands behind back
Rubs palms	Eyes closed	Purses lips
Moves arms	Head tilt	Shakes head
Nods	Blinks	
Laughs	Arms to side	
Widens eyes	Looks away	
Steps	Shrugs	
	Licks lips	
	Lifts eyebrows	

Based on references cited in text.

number of words. The same procedure was followed for the gestures, and then the two rankings were compared. If the order was completely the same, then it was considered a full match. However, if only one measure matched, then it was considered a partial match. Assuming that words emanate from the conscious mind and gestures from the subconscious mind, incongruence between the relative number of words and gestures in each category would suggest that the participant was uncomfortable, or unaware of the emotional effects of the interaction. The following comparisons were made between video data from horse vs. human:

1. Percentage and number of positive words and gestures
2. Percentage and number of negative words and gestures
3. Interview time for each participant
4. Congruence between gestures and words used for each participant

Obviously it was not possible for the student assessors to be blinded regarding whether a given interview being analyzed related to the experience with the horse or the horse substitute person, and so there may have been some bias at play. To minimize this potential problem, each student noted any apparent ambiguities in the classification of a word or gesture and obtained a second opinion from another investigator. If necessary, discussion ensued until a resolution was found.

Statistical Analysis

Paired *t*-tests were run for HRV, sIgA, and self-esteem to test for significant differences between pre versus during or pre versus post for horse-related and control activities. Two-way ANOVA repeated measures procedure was used to test for differences between the effects of the horse interaction versus the control interaction. SigmaStat software was used for the analysis. The Shapiro-Wilk normality test was run for each comparison. Almost all distributions were normal; in the cases of non-normal distributions, the Wilcoxon signed rank test was substituted for the paired *t*-test.

Results

Heart Rate Variability of Horses During Con Su Permiso

The three horses chosen most often (6–7 times each) did not respond in the same way (Table 2). Brown and Sum Punk showed increased HRV, on average, compared to baseline during their interactions with humans. Serra June showed marked decreases in HRV. However, Brown and Serra June showed high percentages of HRV in the VLF range (%VLF, 0.0033–0.05 Hz) before, during, and after interactions with people, while Sum Punk only showed a high %VLF during interactions.

Further analysis of the frequency domain of the horses' HRV data revealed that before and/or during interactions with humans all four horses showed a combination of some of the following VLF HRV peaks (Hz): 0.002, 0.003, 0.004, 0.005, 0.006, 0.012, 0.032.

Table 2 Heart Rate Variability of Three Horses Participating in EFL Exercise, *Con Su Permiso*

Brown	Baseline:	During:	Post:
HR (bpm)	33.30 ± 2.40 (SD)	32.32± 0.62	32.35 ± 0.69
SDNN (ms)	111.08 ± 38.29	124.48 ± 22.43	103.27 ± 22.03
%VLF	69.2 ± 10.8	74.5 ± 14.5	71.5 ± 7.4
Sum Punk			
HR	31.18 ± 3.68 (SD)	36.20 ± 3.68	34.64 ± 2.01
SDNN	159.16 ± 67.62	177.6 ± 48.37	170.64 ± 39.17
%VLF	45.7 ± 13.2	68.2 ± 22.1	46.8 ± 19.6
Serra June			
HR	44.35 ± 3.72 (SD)	40.37 ± 3.63	39.95 ± 4.37
SDNN	111.68 ± 24.31	71.99 ± 16.79	55.15 ± 12.9
%VLF	87.2 ± 7.1	77.4 ± 11.3	63.9 ± 21.6

Data are based on measurements from 6–7 sessions with each horse.

Human Results

Salivary IgA

There were no significant changes in sIgA during interactions with horses (pre: 13.58 ± 8.15 [SD]; post: 12.17 ± 10.45 [SD]; mg/dL, $p = 0.241$, $n = 24$) or with humans (pre: 11.04 ± 6.20 [SD]; post: 12.87 ± 9.31 [SD]; mg/dL, $p = 0.963$, $n = 23$) compared to baseline values. All readings were in the normal range (Jafarzadeh, Sadeghi, Karam, & Vazirinejad, 2010).

Self-Esteem

Both interactions with horses and with humans significantly increased subjects' self-esteem. The effect was greater with horses (pre: 25.42 ± 4.27 [SD]; post: 26.62 ± 4.11 [SD], $p = 0.007$, $n = 24$) than with humans (pre: 25.35 ± 4.94 [SD]; post: 26.13 ± 4.56 [SD], $p = 0.027$, $n = 23$).

Respiration

Interactions with horses (pre: 15.8 ± 4.9 [SD]; during: 29.5 ± 5.6 [SD], $p < 0.001$, $n = 24$) and with humans (pre: 15.5 ± 4.3 [SD]; during: 27.5 ± 5.9 [SD], $p < 0.001$, $n = 23$) both significantly increased subjects' respiration rates.

Heart Rate Variability

Human heart rate increased significantly during interactions with horses and with humans compared to baseline ($p < 0.05$). Heart rate variability (SDRR) also increased during interactions with horses ($p = 0.059$) and with humans, but only significantly with humans ($p < 0.001$). When HRV data were compared between participants who interacted with the horse first vs. the horse substitute person first, there was no significant difference. Therefore, it is unlikely that the HRV experience with the horse on day 1 influenced the HRV experience with the horse substitute person on day 2 and vice versa. During interactions with horses the human HRV frequency spectrum appeared to shift to the VLF range where the horses showed their strongest contribution to HRV (Table 3). However, although the paired *t*-test showed a significant increase in %VLF during interaction with the horse but not during interaction with the horse substitute person (control), the two-way ANOVA repeated measures test did not show a significant difference between interactions with the horse compared to the control. Using one-way repeated measures ANOVA comparing pre versus during for the horse interaction, $F = 2.093$ and $p = 0.165$, whereas for the control, $F = 0.375$ and

Table 3 Heart Rate Variability of Humans Participating in EFL Exercise, *Con Su Permiso*, with Another Human Acting as a Horse Substitute, or with a Mutually Chosen Horse

Interaction with Human (n = 18)			
	Pre:	During:	p-value:
HR (bpm)	74.78 ± 9.38 (SD)	83.33 ± 8.36	$p < 0.001$
SDNN (ms)	29.62 ± 11.20	42.41 ± 17.12	$p = 0.001$
RMSSD (ms)	17.44 ± 12.51	21.17 ± 12.73	$p = 0.089$
%LF	35.57 ± 16.72	32.96 ± 20.45	$p = 0.665$
%HF	11.42 ± 10.27	8.23 ± 5.35	$p = 0.089$
%VLF	53.02 ± 17.78	58.77 ± 22.27	$p = 0.347$
Interaction with Horse (n = 18)			
	Pre:	During:	p-value:
HR	74.78 ± 9.38 (SD)	84.72 ± 7.34	$p < 0.001$
SDNN	31.02 ± 10.82	37.89 ± 12.22	$p = 0.059$
RMSSD	18.48 ± 13.53	17.05 ± 8.32	$p = 0.597$
%LF	33.9 ± 18.45	26.72 ± 12.73	$p = 0.072$
%HF	11.11 ± 9.88	7.87 ± 4.62	$p = 0.146$
%VLF	55.21 ± 20.96	65.43 ± 16.16	$p = 0.043$

The same people participated in both sessions.

$p = 0.550$. Although the more rigorous ANOVA test did not show a significant difference between the effects of the horse and the horse substitute person on %VLF, the paired t-test did indicate a significant increase in %VLF comparing pre and during readings with the horse alone.

Further analysis of the frequency domain of the humans' HRV data revealed that before and during interactions with other humans, there were very few peaks in the VLF range (unlike with horses as noted above for horse HRV data). In addition, there were no matching frequencies shared between more than two people in the participant group. On the other hand, before and during interactions with horses, the majority of humans had 3–5 peaks in the VLF range in their HRV. There were matching frequencies shared between 3 to 6 participants at 0.003, 0.005, 0.029 Hz. When seven of the participants interacted with the horses during *Con Su Permiso*, their own hearts displayed VLF frequency peaks similar to those observed in the horses' hearts (Table 4). This shift was not observed when participants performed *Con Su Permiso* with another human.

Overall, respiration rate, HR, and HRV increased in subjects during *Con Su Permiso* with horses

Table 4 Human/Horse Pairs Showing Matching HRV Frequencies During *Con Su Permiso* Interaction

Human/Horse Names	Matching Frequency (Hz)
Barbara / Serra June	0.045
Dean / Brown	0.024
Marsha D / Brown	0.033
Tia / Chance	0.005
Kathleen / Sum Punk	0.029
Suzanne / Serra June	0.003
Virginia / Serra June	0.005

Frequencies were obtained from frequency domain analysis of HRV recordings.

and with humans (control), and sIgA did not change. The main difference between physiological effects of *Con Su Permiso* with a horse compared to effects with a horse substitute person was that the shift in the human HRV frequency spectrum to the VLF range only happened with horse interactions.

Results from Exit Interviews

Exit interviews lasted approximately the same time on average when describing horse interactions (86.5 s ± 27.5 [SD]) compared to human interactions (91.9 s ± 33.9).

Word usage about both types of interactions reflected significantly more positive than negative feelings and emotions ($p < 0.001$ for horse interactions, $p = 0.013$ for human interactions; Table 5). There were no significant differences in corresponding numbers of positive, neutral, and negative words used comparing horses and humans.

Overall, participants used significantly more gestures than words when expressing emotions and feelings regardless of whether they were describing interactions with horses or humans. As for word usage, gesture usage reflected significantly more positive than negative feelings and emotions ($p < 0.0001$ for horse and for human interactions; Table 6). However, there were significantly more positive gestures ($p < 0.02$) and significantly fewer negative gestures ($p < 0.003$) used for horses than for humans. These results were confirmed using the more rigorous two-way ANOVA repeated measures test followed by Holm-Sidak pair-wise comparisons.

The words and gestures used when discussing the horses were more congruent with each other than when discussing the interactions with the humans. There were more perfect matches and fewer no matches in rank order of types of words and gestures used (Table 7).

Discussion

Main Findings and Importance of Results

The results from this study are partially consistent with our hypothesis in that when older people with no diagnosed disabilities participated in *Con Su Permiso*, they became more aware of their bodily sensations and emotions, leading to increased HRV and self-esteem. Although their immune function,

Table 5 Valence of Word Usage by Participants During Exit Interviews after *Con Su Permiso* Horse and Human Interactions, Relating to Sensations and Feelings They Experienced

	Interaction with Horse	Interaction with Human	*p*-value
Positive:	4.42 ± 3.31 (SD)	3.17 ± 2.79 (SD)	0.171
Neutral:	4.08 ± 2.39	4.61 ± 3.45	0.622
Negative:	0.58 ± 1.61	1.0 ± 2.02	0.547

Table 6 Valence of Gesture Usage by Participants During Exit Interviews after *Con Su Permiso* Horse and Human Interactions, Relating to Sensations and Feelings They Experienced

	Interaction with Horse	Interaction with Human	*p*-value
Positive:	20.21 ± 6.58 (SD)	17.72 ± 6.14 (SD)	0.020
Neutral:	9.25 ± 5.24	8.29 ± 4.26	0.476
Negative:	2.58 ± 1.84	5.17 ± 3.28	0.003

Table 7 Congruency between Valence of Words and Gestures Used During Exit Interviews

	Interaction with Horse	Interaction with Human
Perfect Match:	9	3
Partial Match:	13	15
No Match:	2	5

Relative congruency of words and gestures was determined by counting the numbers of "perfect matches" and "no matches" in rank order of types of words and gestures used.

as measured by sIgA, did not increase, it was still maintained at normal concentrations. It is possible that if a group of participants with insufficient sIgA had been studied, these values would have increased with EFL.

Although the benefits of *Con Su Permiso*, such as increased HRV and self-esteem, still occurred when the interaction involved another person instead of a horse, the results of this study provide valuable new information about how horses and humans affect each other physiologically and psychologically. *Con Su Permiso* with horses not only increased HRV (SDNN) in human participants, but also increased their HR and respiration rates, suggesting that engaging with horses is beneficial and induces an enlivened state without stress. This response is in contrast to that of experienced riders, riding a prescribed course, whose RMSSD increased, indicating relaxation. Even though the participants performing *Con Su Permiso* showed increased heart and respiration rates, it is unlikely that they were emotionally stressed, because if so the parasympathetic component of their HRV (RMSSD and %HF) would have significantly decreased (Porges, 2003; Traina et al., 2011), as would their sIgA (Afrisham et al., 2016).

An unexpected result was the predominance of HRV in the VLF range shown by the horses and its subsequent appearance in the humans as they interacted with them. It was predicted that *Con Su Permiso* would produce a predominance of HRV in the LF range, consistent with a reduced breathing rate, but since the participants actually increased their breathing rate, the lack of power in the LF range is not surprising. Experiments in humans by other investigators indicate that people with a low %VLF in their HRV are prone to PTSD (Shah et al., 2013), inflammation (Lampert et al., 2008), and death from cardiac arrhythmia (Bigger et al., 1992). Veterans with PTSD report experiencing EFL programs as beneficial (Brooks, 2012). The present study suggests that *Con Su Permiso* may somewhat increase %VLF in participants, which is consistent with the beneficial effects of EFL experienced by veterans with PTSD. Results of the next phase in this study, Mindful Grooming (currently being drafted for submission for publication), have shown a more pronounced shift in participants' HRV to the VLF range. Further research on this topic might reveal whether the VLF contribution to HRV plays a role in the reported healing of military personnel and others suffering from PTSD.

Con Su Permiso also appeared to improve the nonverbal communication skills of participants. With horses the words participants used in their descriptions were more in tune with their gestures compared to the words they used with humans, reflecting an improved ability to accurately express emotions through gestures. According to McNeill (1992), gesture and speech combine to reveal meaning that is not fully captured in one modality alone. Clinical evidence supports the concept that when a horse senses inconsistencies in a person's behavior, body language, odors, and /or voice tone, it appears less at ease and reluctant to engage with the human (Hallberg, 2008). When humans are consistent in the way they display an emotion (matching behavior with expressed emotion), the horse is more likely to engage with them. Thus EFL could be providing an effective teaching tool to help people learn how to achieve harmony and congruency between mind and body, leading to improved body awareness and self-regulation.

This study is the first to simultaneously monitor HRV in horses and humans as they interact in EFL situations. The research is unique because it emphasizes how horses and humans affect each other, rather than how they both react to outside stimuli

as reported in a previous study (Drinkhouse et al., 2012). Information about horse-human interaction is vital to ensure that appropriate EFL exercises are selected to optimize benefits for horses and humans in a given situation. In addition, measuring the HRV of horses during their interactions with humans provides some insight into their suitability for the work in terms of whether or not it benefits them physiologically. Further data are required from more horses to determine whether a change in HRV during EFL activities is an effective biomarker for suitability for EFL. In future studies, filming of Mutual Choosing between horse and human, which was not included in the present study, may help professionals learn the nuances of the horse's behavior as it chooses its human partner and offer indicators of a horse's affinity for engaging in the work.

Limitations of the Study

One limitation of the inherent design of the EFL process is that the participant is being watched and recorded while doing something unfamiliar. This may explain why participants' HRV increased, but not significantly, during EFL. The EFL exercise, *Con Su Permiso*, is a three-phase interaction (mutual choosing, say hello, scanning palms around horse's body) that involves dividing one's attention between self, coach, and horse simultaneously. It is possible that the subjects were more anxious about performing well with the horses than with the humans, since the human interaction served as the control condition. Anxiety decreased overall HRV (VLF, LF, and HF combined) (Chalmers, Quintana, Abbott, & Kemp, 2014), which may explain the lack of a statistically significant increase in HRV when participants interacted with horses.

A second limitation was that the time interval between preactivity and during, and between during and postactivity HRV measurements varied among participants. In order to standardize these intervals, each of the participants would have had to experience the whole process by him or herself rather than as part of a group. It was decided to use groups because this situation resembles real EFL sessions. To minimize the degree of time interval variation, the groups were kept small (4 people). For each person, any excess time between measurements was spent in the experimental area in the presence of horses and other participants.

Third, during exit interviews following human interactions, there was less congruency between words and gestures than in interactions with horses (Table 7). It is possible that human reluctance to speak negatively of another human played a factor. We recommend that in future, the horse substitute people do not have other staff roles in the study so that participants do not have a chance to bond with them in advance.

Last, since most of the participants in this study were female, these results might not necessarily apply to males. Further studies are needed to determine differences in responses of males and females to EFL.

Summary for Practitioners

Equine-facilitated learning (EFL) helps people access their immediate sensations and feelings because horses, as prey animals, are continually aware of their environment and provide instant feedback to human behaviors and emotions. We hypothesize that during EFL, older people become more aware of their bodily sensations and emotions, leading to increased heart rate variability (HRV), improved self-esteem, and improved immune function. Adults in mid- to late life, in particular, are prone to physiological and psychological disorders related to autonomic imbalance, such as hypertension, cardiovascular disease, immune dysfunction, anxiety, depression, and low self-esteem. If such individuals are able to develop some degree of autoregulation through greater awareness of their sensations and feelings, they may become less susceptible to these widespread disorders.

Physiological information about horse-human interactions is vital to ensure that appropriate EFL exercises are selected to optimize benefits for horses and humans in a given situation. Heart rate variability is a

well-established biomarker of autoregulation; higher variability indicates improved cardiovascular function, emotional health, and social engagement, while a low HRV is associated with depression and even panic disorder. Heart rate variability is increased by body awareness therapy, in which participants focus on their sensations and emotions. During *Con Su Permiso*, the form of EFL used in this study, facilitators encourage clients to observe feelings and sensations in their body that arise from focusing on the horse.

Since EFL involves horses as well as people, it is important for the success and integrity of the whole process that the horses themselves are not stressed. Horses are social animals and respond to external stimuli that may go unnoticed by the facilitators or handlers, resulting in increased stress. Heart rate variability was measured in each horse before, during, and after *Con Su Permiso* to determine whether the exercise changed their stress levels and whether their HRV showed any synchronicity with that of their human partners.

Twenty-four subjects (age > 55) participated in a single 15-minute session of *Con Su Permiso*, during which they focused on their own bodily sensations and on the responses of the horse as they approached and moved around the horse. Subjects served as their own control, interacting with a human in another session. Apart from HRV measures on humans and horses, pre and post self-esteem scores and immune response (salivary immunoglobulin A, sIgA) were obtained from humans. All equine and control interactions were video recorded, and an exit interview was conducted after each interaction. Words and gestures relating to feelings and sensations were categorized as positive, neutral, or negative.

Human heart and respiration rates increased significantly during interactions with horses and with humans compared to baseline. Heart rate variability (SDRR) and self-esteem increased during interactions with horses and humans, but sIgA did not change. These findings support our hypothesis and suggest that engaging with horses or humans during *Con Su Permiso* benefits people, indicating an enlivened state without stress. In three of the four horses HRV consistently increased during the exercise, indicating a healthy response, but HRV decreased in one horse, reflecting less effective vagal control of the heart. This particular horse had just lost her stablemate and died herself a few months later, and so it is unlikely that her response was caused by the EFL. The HRV data from the horses indicate that this measure is a valuable biomarker for equine stress and provides some insight into their suitability for the work in terms of whether or not it benefits them physiologically.

Although the benefits of *Con Su Permiso*, such as increased HRV and self-esteem, still occurred when the interaction involved another person instead of a horse, there was one response that was only produced by the horse; that was the slight shifting of the human HRV frequency spectrum to the very low frequency (VLF) range where most of the HRV in horses occurs. This finding is important because other studies indicate that people with a low contribution of VLF in their HRV are prone to post-traumatic stress disorder (PTSD), inflammation, and death from cardiac arrhythmia. Therefore, experiences that increase the VLF contribution will be beneficial, particularly for those suffering from PTSD. Further research on this topic might reveal whether the VLF contribution to HRV plays a role in the anecdotal instances of healing of military personnel suffering from PTSD when they participate in EFL.

During exit interviews, participants used significantly more positive and fewer negative gestures describing the equine experience compared to the control. *Con Su Permiso* also appeared to improve the nonverbal communication skills of participants. With horses the words participants used in their descriptions were more in tune with their gestures compared to the words they used with humans, reflecting an improved ability to accurately express emotions through gestures. When humans are consistent in the way they display an emotion (matching behavior with expressed emotion), the horse is more likely to engage with them. Thus EFL could be providing an effective teaching tool to help people learn how to achieve harmony and congruency between mind and body, leading to improved body awareness and self-regulation.

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Continuum Palliative Resources

Continuum Palliative Resources (CPR) is a home-based palliative care program provided to Continuum Hospice & Palliative Care patients with a progressive chronic illness to help improve their overall quality of life. Our highly skilled staff works with patients and family members to establish an effective health care plan that will enhance treatment, provide comfort and manage symptoms.

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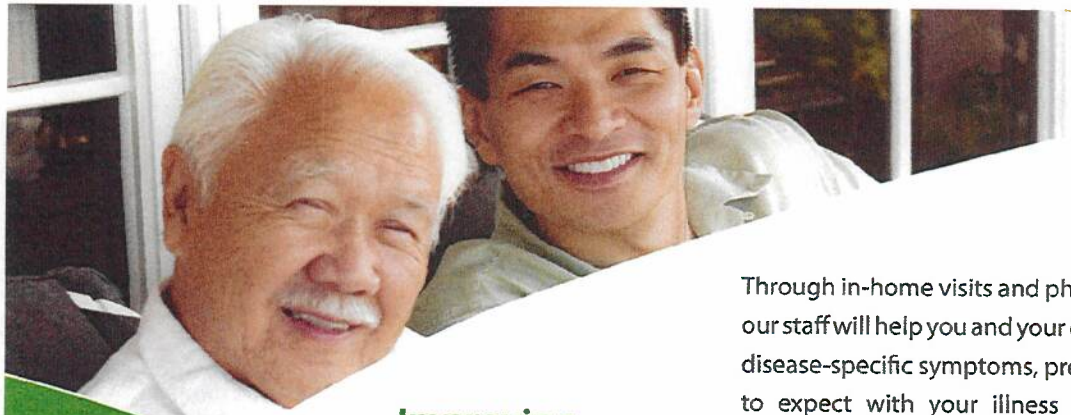

Improving Quality of Life

When you have a chronic illness such as congestive heart failure (CHF) chronic obstructive pulmonary disease (COPD), dementia, or stage IV cancer, you may find yourself feeling overwhelmed as your disease progresses. Continuum Palliative Resources (CPR) uses home-based palliative care to enhance your daily lifestyle through education, medication management and caregiver support.

The CPR program is a consultative service and is personalized to address your unique physical, emotional and spiritual needs. Our team includes a physician, nurse practitioner, social worker and support staff who will coordinate care with your physician.

Through in-home visits and phone consultations, our staff will help you and your caregivers manage disease-specific symptoms, prepare you for what to expect with your illness and connect you with community resources. We will also provide support specifically for your primary caregiver to make sure his or her needs are being addressed. It's all part of the extraordinary level of care you can expect from Continuum Care.

WE ARE COMMITTED TO DELIVERING COMPASSIONATE CARE TO YOU AND YOUR FAMILY THROUGHOUT YOUR CHRONIC ILLNESS.

We help you and your family or caregiver:

- Define a more comprehensive plan of action that can grow and change with your condition
- Manage disease-specific symptoms such as nausea, pain, anxiety, fatigue and shortness of breath
- Take a proactive role in managing your disease
- Communicate with your physician about your health care needs
- Access community resources

Eligibility for Continuum Palliative Resources

CPR is designed for patients with advanced chronic illness such as congestive heart failure, chronic obstructive pulmonary disease, dementia, or stage IV cancer.

We are committed to delivering compassionate care to you and your family thoughout your chronic illness. For additional information about the CPR program, call:

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Napa/Sonoma: 707-540-9838
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In-Service Packet, Including Shalom Hospice Philosophy, Mission and Goals

SELF-LEARNING IN-SERVICE PACKET

SHALOM
HOSPICE

PHILOSOPHY

Hospice care affirms life. It is a concept of care, rather than a place. This type of care specializes in providing comfort through skillfully managing the patient's symptoms. The care focuses on enhancing the quality of life while neither hastening nor prolonging the quantity of life.

Hospice provides a comprehensive range of professional and supportive health care, addressing the palliation of physical, psychosocial and spiritual pain and other symptoms caused by the terminal disease process. This team of caregivers coordinates their interdisciplinary efforts in meeting the needs of terminally ill patients and their loved ones.

SHALOM HOSPICE'S MISSION

The mission of Shalom Hospice is:

- To provide the highest quality hospice care in the most cost effective manner
- To give dignity to the dying experience
- To provide access to care for all persons
- To educate the community

GOALS

The goal of the Hospice/nursing facility program is to provide the best possible care for the patient with life-limiting illnesses by:

- Working with the nursing facility's staff to achieve optimal pain and symptom control management
- Collaborating with nursing facility staff regarding the resident's care needs
- Providing specialized ongoing training and education for nursing facility personnel concerning care of the terminally ill and family issues related to death and bereavement
- Addressing the physical, emotional, social and spiritual needs of the residents and their families

WHO WE CARE FOR

Shalom Hospice cares for any resident who is suffering from a life-limiting illness. The term "life-limiting" refers to any illness that has progressed to the point where the physician estimates a prognosis of 6 months or less.

Medicare/Medicaid and the National Hospice Organization provide guidelines to help determine when a resident is hospice appropriate.

Some examples of diagnoses that may be considered hospice appropriate are patients in end stages of:

- Cancer
- AIDS
- ALS (and other neurological diseases)
- Alzheimer's disease (stage 7)
- Cardiac disease
- Lung disease
- Renal disease
- Liver disease

*** **Hospice patients have chosen palliative care rather than curative.**

HOSPICE CRITERIA

Some general criteria that Shalom Hospice uses in assessing hospice appropriateness are:

- Patient and family desire comfort care only
- Progressive decline in patient activity and functional status
- Multiple hospital admissions for symptom control
- Several secondary diagnoses
- Decline in nutritional status
- Documented evidence of disease progression
- Decreased mental status

LEVELS OF CARE
There are four levels of care under the Medicare Hospice Benefit

- **Routine:** Traditional level of care received at home or in a nursing facility.
- **Continuous care:** Short term care provided during periods of crisis to maintain the patient at home. Primarily nursing and aide care.
- **Respite:** A period of up to 5 days in which a patient is removed from the home to relieve care givers.
- **Inpatient:** Short term for pain or other uncontrolled symptoms.

ADMISSIONS PROCESS

Anyone can refer a resident to hospice! Family members, physicians, friends, nursing facility staff and even members of the resident's clergy make referrals.

Once a referral is received the hospice admissions staff will contact the patient's primary physician to ascertain if the patient is appropriate. Medical records will be reviewed and the hospice staff will then visit with the resident and family to explain hospice services and to ascertain resident and family wishes.

Our goal is to admit residents to hospice care within 24 hours of a completed referral.

Referral made to Shalom Hospice
↓
Call made to primary physician to certify the patient has a terminal illness
↓ ↓
Physician agrees resident is hospice appropriate | **Physician denies hospice appropriateness**
↓
Insurance information is verified. Patient/family notified of eligibility to receive hospice services
↓
Shalom Hospice staff meet with patient/family to discuss hospice services and obtain informed consent (SNF staff may be present for this meeting also) → **Patient/family decline hospice Service (Physician and SNF will be notified if this occurs)**
↓
Patient/family consent to hospice
↓
Billing department is notified
↓
Specialized plan of care is jointly developed between patient, family, SNF and hospice staff

WHAT WE PROVIDE

- Specialized comfort care
- Medical supplies related to the hospice diagnosis
- Durable Medical Equipment related to the hospice diagnosis
- Medications for pain and symptom management of the hospice diagnosis
- Short term hospitalization if indicated by the hospice plan of care
- Continuous care when indicated
- Family counseling during the illness
- Laboratory and diagnostic services if indicated in the hospice plan of care
- Transportation if indicated in the hospice plan of care
- Physical/Occupational/Speech therapy if indicated in the hospice plan
- Bereavement support to family, residents and staff as needed

MEMBERS OF THE HOSPICE TEAM

- **Patient's Primary Hospice Physician:** Directs the Care Plan
- **Hospice Medical Director:** Oversees the Care Plan
- **Nursing:** Initiates the Care Plan together with patient, family, SNF staff and members of the Interdisciplinary Team. Coordinates the hospice care. Expert in symptom control and comfort with the terminally ill.
- **Social Workers:** Performs psychosocial assessment on the patient and family. Assesses the patient/family needs and assists with long-term planning, coping, funeral arrangements, accessing additional services appropriate to needs.
- **Hospice Aides:** Provide personal care to the hospice patient and housekeeping duties as directed by the care plan.

- **Trained volunteers:** Provide a variety of tasks for the hospice patient and family such as handholding, reading to the patient, helping prepare meals, friendly visitation and respite for the caregiver.

- **Therapists:** Provide physical, occupational, or speech therapy to hospice patients as indicated in the hospice plan of care.

- **Dietician:** Provides consultation on the special dietary needs of some hospice patients.

- **Counselors:** Work with patients and families to assist with coping, grief work and bereavement care (13 months)

- **Chaplain:** Addresses the spiritual needs and concerns of hospice patients and their loved ones

PATIENT RIGHTS

Hospice patients have the right to be informed of his or her rights, and the hospice must protect and exercise these rights. Shalom Hospice complies with federal, State and local requirements in regard of patient rights. At a minimum the patient has a right to:

- Effective pain management and symptom control
- Involvement in developing his or her plan of care
- Refuse care or treatment
- Choose his or her attending physician
- Have a confidential clinical record
- Be free from mistreatment, neglect or verbal, mental, sexual and physical abuse, including injuries of unknown source and misappropriation of patient property
- Receive information about the services covered under the hospice benefit
- Receive information about the scope of services the hospice will provide and specific limitations to those services.

COORDINATION OF SERVICES

The coordination of services is an important process to enhance the care and management of the hospice patient.

Expectations

- Communication regarding the provision of care with facility staff and physician
- Knowledge of the interdisciplinary team member responsible for care.

Information you can expect to receive:

- The hospice plan of care
- Advance directives
- Physician certification and recertification
- Names and contact information of hospice personnel
- Instructions on how to contact hospice on call
- Hospice medications
- Hospice physician orders if pertinent
- All interdisciplinary notes and assessments

WHEN TO CONTACT HOSPICE

Shalom Hospice is responsible for the management of the patient's hospice care and for charges incurred to provide that care. It is for that reason that **IT IS IMPERATIVE TO NOTIFY SHALOM HOSPICE OF ANY OF THE FOLLOWING:**

- A change in a patient's physical, mental, social or emotional status occurs.
- Clinical complications that suggest a need to alter the plan of care
- A need to transfer the patient from the facility, as the hospice retains responsibility for any continuous care or inpatient care necessary related to the terminal illness
- Patient death

We are available 24 hours a day, 7 days a week. Together we will make a determination with the patient's attending physician as to the appropriate treatment of the patient. If it is agreed upon that a transfer is needed, Shalom Hospice will arrange the transport. Please note if the patient has a ***DO NOT HOSPITALIZE*** order on the chart.

COMMUNICATION IS THE KEY TO PROVIDING THE BEST CARE FOR THE PATIENT

PAIN AND SYMPTOM MANAGEMENT

Shalom Hospice's mission is to enhance dignity at end of life. Pain and symptom lies at the heart of hospice care. Medical, pharmacological, and complementary therapies may help control a range of debilities that if left untreated reduce the patients will, strength and dignity.

Professional expertise and an individualized plan of care make pain and symptom control possible. The hospice team and facility staff collaborates to improve pain and symptoms so that our patients can function optimally while maintaining dignity.

DEATH AND DYING

The Dying process
The dying process begins well before death actually occurs. Death is a personal journey that each individual approaches in their own unique way. There are many paths one may take but only one destination.
There are milestones on this journey but because everyone experiences death in their own way, not everyone will stop at each milestone. Listed below are common milestones

One to three months prior to death

- Patient may begin to withdraw
- Begin to contemplate life
- Appetite wanes
- Energy level decreases

One to two weeks prior to death

- Patient may sleep more and become disoriented
- Vital signs decrease
- Increased perspiration
- Skin color changes in response to circulation decrease
- Breathing changes
- Loss of ability to speak

A couple of days to hours before death

- Breathing becomes more irregular
- Hands and feet may become mottled
- Patient usually unresponsive

"Death is not extinguishing the light; it is putting out the lamp because the dawn has come"

Rabindranath Tapore

DEATH OF A HOSPICE PATIENT

Shalom Hospice is available **24 hours a day, 7 days a week.** As it becomes apparent that a hospice patient is approaching death, Shalom Hospice becomes even more present to ensure physical, psychosocial and spiritual comfort. We will be working with the patient, family and facility staff to provide comfort, education and support as the patient proceeds through the dying process.

If a Shalom Hospice patient passes away while the hospice staff is not present, the facility will notify the hospice of the patient's death. It is then jointly determined if the hospice or the facility will notify the physician, family, funeral home and who will pronounce the patient.

If necessary, the hospice nurse will visit the facility at the time of death to provide support to the family, other residents and staff as well as to provide the after death care of the patient. If the hospice nurse is present for the death, this will occur immediately.

Even if your facility wishes to notify the family of the patient's death, the hospice staff will issue follow-up contact soon after the death to offer support and explain the bereavement program. Bereavement services are also available to fellow residents and staff as identified on the plan of care. Closure is important for both the survivors and the hospice staff.

INPATIENT LEVEL OF CARE

General inpatient level of care is available to hospice patients in need of inpatient pain or symptom management that cannot be provided in other settings.

In most cases the decision to change a patient's level of care is based on the clinical condition of the patient. Hospice inpatient requires the documentation of an acute change in the patient's condition, necessitating aggressive, intensive treatment for management of symptoms. Examples include:

Pain requiring:

- Complicated technical delivery of medication requiring RN for calibration, tubing changes, or site care;
- Frequent evaluation by physician or nurse
- Aggressive treatment to control pain and frequent medication adjustment.

Symptom changes such as:

- Sudden deterioration requiring intensive nursing intervention;
- Uncontrolled nausea and vomiting
- Pathological fractures
- Respiratory distress
- Open lesions requiring frequent skilled care
- Complex wound care

Psychological and social problems such as:

- Acute anxiety, fear of dying or depression requiring intensive nursing interventions
- Collapse of family support and patient requires intensive skilled care

Patient/Family teaching:

- Complex treatments or medications

Imminent death:

- Requires skilled nursing care for pain or symptom management.

COORDINATION OF CARE AND SERVICES FOR INPATIENT LEVEL OF CARE

The coordination of care and services is an important process to enhance the care and treatment of the hospice patient.

Hospice Responsibilities:

- Hospice shall evaluate, authorize care and arrange for admission of patients requiring inpatient level of care
- Hospice staff shall coordinate the palliative services provided to each patient by reviewing the plan of care and treatment with the staff. Hospice shall provide a copy of the patients plan of care
- Hospice shall communicate effectively with the facility staff.
- Hospice shall document in the patients record

Facility Responsibilities:

- Facility shall designate an individual responsible for implementation of the written agreement
- Staffing patterns will meet the standard of 24 hour nursing services sufficient to meet the patient/family needs
- The environment will be home-like and promote privacy and comfort.
- Visitors will be permitted 24 hours a day and accommodations will be provided for families to stay overnight.
- All orders, events will de documented and communicated with the hospice team
- On discharge a discharge summary will be completed and hospice will have access to patient records.

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INFECTION PREVENTION AND CONTROL

Performance Improvement Plan

I. INTRODUCTION:

The Performance Improvement Plan for the infection control program reflects Shalom Hospice's mission statement, vision and values.

The Performance Improvement Plan for infection control has been developed based upon the demographics of the population served. The population is diverse and patients may be referred to Shalom Hospice from any area of the state. The demographics reflect a large geriatric population with terminal illnesses, who are immunocompromised and have underlying chronic conditions.

The plan is inclusive of the home care population, types of the infections and pathogens identified, the identified opportunities for improvement, current literature and recommendations from Centers for Disease Control and Prevention (CDC), Community Health Accreditation Program (CHAP), American Association of Medical Instrumentation (AAMI), and the Federal and State standards/regulations.

II. PURPOSE and SCOPE of PERFORMANCE IMPROVEMENT PLAN:

The purpose of the plan is to provide quality care to the patients served by Shalom Hospice and to perform activities that will reduce the risk of transmission of infection to patients, staff and families. The plan has been established for the purpose of prevention and control of healthcare acquired infections.
The scope of service incorporates the patients, families, employees, and the community. The scope of service is reviewed annually and is revised according to the needs of all of the above plus quality improvement findings, revised standards and updated knowledge regarding infectious diseases.

The infection surveillance system, educational programs and the development of policies and procedures for the prevention and control of infections is designed to assist all healthcare workers in providing quality patient care.

III. GOALS and OBJECTIVES of the PERFORMANCE IMPROVEMENT PROGRAM

The goals of the Infection Prevention and Control Performance Improvement Plan are as follows:

To provide the means for tracking and identifying health care associated infections in order to provide information that will assist in determining opportunities for improvement of patient care.

To continuously monitor surveillance data, infection control practices and patient outcomes.

To provide education to all staff members based upon this information, regarding ways to improve the prevention and control processes to reduce health care associated infection rates to the lowest possible level.

To provide an Infection Control program that will protect staff and patients from infections, including but not limited to exposure to bloodborne pathogens, tuberculosis, antibiotic resistant organisms and communicable diseases.

The objectives of the Infection Control Performance Improvement Plan are to:

Identify all health care associated infections through total surveillance in order to establish base line data and identify areas for risk reduction. Targeted or focused study will be performed in the event that any infection control problems are identified.

Monitor all culture results to identify patients with multiple drug resistant organisms and other significant organisms so the appropriate precautions can be instituted to prevent transmission. Monitor microbiological trends to identify clusters or outbreaks of infections.

Educate staff regarding general infection control practices, infection rates and opportunities for improvement through methods of prevention, changes in practice as mandated by regulatory agencies, and changes in infection control policies and procedures.

Educate patients, family members, and caregivers regarding general infection control practices to prevent the spread of infection in the home setting.

Evaluate infection control practices when conducting supervisory home visits and identifying opportunities for improvement.
Implement appropriate action, based upon the analysis of data gathered, and evaluate the effectiveness of the designated action on an ongoing basis.

SCOPE of MONITORING ACTIVITIES

A. Infection Surveillance:

Based upon this population, as well as the increased risk of infection, total surveillance is conducted on an ongoing basis to identify areas for improvement. The surveillance indicators include, but are not limited to:

- Vancomycin Resistant Enterococcus (VRE)
- Methcillin Resistent Staphlococcus Aureus (MRSA)
- Glycopeptide Intermediate Staphylococcus Aureus (GISA)
- C. difficile associated diarrhea
- All health care associated infections
- Clusters and outbreaks of infection

Note: Surveillance activities in home care shall not include identification and measurement of community acquired infections. Included are upper and lower respiratory infections (e.g. colds, flu, pneumonia) gastrointestinal infections (e.g. nausea, vomiting, diarrhea and viral gastroenteritis), and other common illnesses that occur as a result of exposure to the community.

Data collection methods include concurrent and retrospective review to include:

- Review of 100% of the Intake sheets for infectious diseases, readmission due to possible health care associated infection and potential reportable diseases
- Review of 100% of microbiology reports to identify health care associated infection or clusters of infection
- Review of 100% of Infection Identification Patient Reports Physician diagnosed infections
- Clinical evidence such as temperature and subjective data from patient information obtained from medical records
- Information provided by staff members
- Review of telephone orders prior to data entry to identify newly prescribed antibiotics

Definition of Home Care Acquired Infection and Analysis of Infections

- Evidence that the infection was not present or incubating at the time of admission should be established.
- Symptoms or abnormal findings occurring greater than 48 to 72 hours after admission should prompt further investigation. There are exceptions to this and incubation periods must be taken into consideration to avoid counting infections that originated at other sites of care, i.e. chicken pox, surgical wound infection.

Shalom Hospice shall follow the Center for Disease Control and Prevention's National Healthcare Safety Network (NHSN) definitions in regards to Bacteremias and Urinary Tract Infections. The Home Health Definitions shall be utilized to determine other infections. Care must be taken to distinguish between infection and colonization and community acquired infection. Definitions follow this plan.

Analysis

The numerator is the number of health care associated infections for a particular site. The denominator is the number of patients at risk for that infection or the number of days at risk (e.g., total number of catheter days for all patients with indwelling urinary catheters during the surveillance period).
Denominators for infection by site:
Catheter-associated UTI……Total number of catheter days for all patients with indwelling Foley catheters
IV related bloodstream infection…….Total number of catheter days for all patients with venous access devices

B. Additional Monitoring Indicators:

- Monitor suspect and confirmed tuberculosis cases to ensure compliance with the TB Control Plan

- Monitor and evaluate infection control practices through chart review and home visits

- Monitor employee exposures and compliance with the Exposure Control Plan and evaluate findings to identify opportunities for improvement. These may include safer sharps safety devices, additional personal protective equipment, changes in work practices, etc.

C. Policy Review

- Review Infection Control policies and procedures annually and revise as needed. Revised policies will be submitted to the Infection Control Committee for review and approval.

- Develop new Infection Control policies as identified by the policy needs assessment. New policies and procedures are submitted to the Infection Control Committee for review and approval.

- New and revised Infection Control policies will be presented to staff at staff meetings by the Program Director or her designee.

- The TB Exposure Control Plan will be reviewed annually and revised, when indicated. A TB risk assessment will be performed annually for each office.

- The Exposure Control Plan will be reviewed annually and revised, when indicated. The annual review will include evaluation of exposure incidents. Available medical devices will be considered to reduce the risk of needlestick and sharps injuries. Exposure incidents related to work practices and personal protective equipment will be evaluated to identify the need a) for education, b) to change or alter work practices and c) to evaluate the adequacy of personal protective equipment. The plan will be revised to include the most recent guidelines from the Center for Disease Control and

Prevention on vaccinations against Hepatitis B virus and post exposure evaluation and follow up for HIV and Hepatitis C exposures.

D. Employee Health

Employee Health is an integral part of the infection control program. The Program Director is responsible for data collection, assessment, evaluation, reporting and follow-up on employees for the following:

- TB reactor data
- Needlestick and sharps injuries data and analysis
- Significant exposures data and analysis
- Epidemiological links among health care workers
- Work restrictions related to communicable diseases
- Communicable diseases exposure contact follow up

The Program Director will forward information and reports to the Coordinator of Performance Improvement (PI). The Coordinator of PI will present findings to the PIC and Infection Control Committee.

E. Education

- Education regarding infection control and prevention and policies is accomplished through formal and informal inservices.

- An inservice on Bloodborne Pathogens and the TB Control Plan shall be presented to all new orientees and, at least annually, to all other healthcare workers.

- A basic infection control and prevention inservice shall be presented annually.
- Special educational sessions will be conducted based upon need and request.

- An annual educational needs assessment will be conducted to determine programs of interest to staff members.

- Written education regarding infection prevention and control will be provided for all patients, family members and caregivers upon admission to service.

IV. PROGRAM IMPLEMEMTATION

Under the direction of the Infection Control Chairman, the Clinical Director is responsible for assisting staff in data collection for surveillance, educational programs, policy development and revision, compliance with local state and federal regulations, employee health and other process improvement measures to ensure quality patient care and minimize transmission of infection. The Clinical Director will ensure that there is

periodic monitoring of employee compliance with infection control practices and procedures.

The Performance Improvement Coordinator is responsible for collection of surveillance data and verification of information submitted by staff members. Surveillance reports will be written and analyzed by the PI Coordinator. Reports will be presented at quarterly PIC meetings and annually at Infection Control Committee meetings. Data will be reviewed with the Professional Advisory Committee. Evidence of clusters of infections, infections related to a specific procedure or other significant findings will be reviewed immediately with the Chairman of Infection Control committee and the Clinical Director.

Formulation and execution of the Performance Improvement Plan (PIP) for Surveillance Prevention and Control of Infection is the responsibility of the Infection Control Committee, under the leadership of the Chairperson and Clinical Director and the Performance Improvement Coordinator. The Infection Control Committee is multidisciplinary and meets at least annually to guide and evaluate the program. Additional committee meetings will be held when indicated.

Outcomes of the data collection and analysis are presented to the Performance Improvement Committee and the Infection Control Committee with feedback to the appropriate team. The Clinical Director will present findings to staff members at team/staff meetings.

There is communication of infection control data throughout the organization and between facilities when necessary. Infections that are identified, that may have been acquired while in another facility, will be reported back to that facility by the Performance Improvement Coordinator

The infection control consultant will attend Infection Control Committee meetings, act as a resource to the organization and will be available as required for consultation by telephone.
The infection control and prevention program is directed by the recommendations and approvals of the Infection Control Committee, the Centers for Disease Control and Prevention guidelines, the local, state and federal regulations, CHAP standards and current literature.

VI. CONFIDENTIALITY OF INFORMATION

Data generated through Performance Improvement activities through the Hospice is considered confidential. Performance Improvement data will be released only to authorized persons employed by or affiliated with the Hospice and the agencies and institutions authorized by Administration

VII. APPRAISAL/EVALUATION of the PERFORMANCE IMPROVEMENT PROGRAM

The Infection Control Committee, with assistance from the Performance Improvement Coordinator and the Clinical Director, evaluates the effectiveness of the Infection Control Performance Plan annually and as necessary.

The basis for evaluation includes:

A. A summary of relevant findings, actions required to improve the coordination or integration of activities within the program and evidence of the program's impact on reducing the incidence of infection and improving the quality of patient care.

B. Identification of components of the program that need to be instituted, altered, or deleted. Recommendations should assure that the program is ongoing, comprehensive, and effective in improving infection control practices and reducing infection rates.

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Garner, J., Javis, W., Emori, T., Horan, T., & Hughes, J. (1988) CDC Definitions for Nosocomial Infections. American Journal of Infection Control, 16, 128-140.

Rhinehart, E & Friedman, M. (1999). Infection Control in Home Care. Maryland: Aspen Publishers, Inc.

The Association for Professionals in Infection Control and Epidemiology (2005). APIC Text of Infection Control and Epidemiology, Volume 1, sections 1, 2, 3, 9, and 52.

Centers for Medicare and Medicaid Services; Final Medicare Hospice Conditions of Participation 2008 (418.60: Infection Control)

Original Date of PIP: 5/00
Revised: 2001, 2008
Reviewed: 2002, 2003, 2004, 2005, 2006, 2007, 2009, 2010

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Quality Assessment and Performance Improvement Plan (Sample)

Shalom Hospice of Southeast Tennessee

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMEMNT

Agency Quality Assessment and Performance Improvement

Structure

The agency's Quality Assessment and Performance Improvement {QAPI) Committee identifies and addresses quality issues and implements corrective action plan as necessary.

Mission

Shalom Hospice's mission is to provide the terminally ill patient and their loved ones with the support and care they require to live their lives comfortably. Our Hospice team strives to enable the patient and family to maintain dignity and quality of life.
Our goal is to provide physical, emotional, and spiritual comfort. We strive to empower the patient and family by providing them with the tools, information and support they need to make informed decisions. We provide ongoing support for family and friends for as long as it is needed.
We believe that Hospice care should be available to any and all persons with an illness for which there is no cure or for persons who elect not to attempt a cure, resulting in a limited life expectancy.

To carry out this mission, the agency provides:

- Relief of pain and other symptoms of illness on a 24 hour-a-day basis
- An end of life program focused on the dying patient and families overall well-being, caring for the mind, body and spirit.

- Education to families, caregivers, and the community at large in the areas of death and dying, grief, hospice and palliative care.

Membership

The Executive Director is the chairperson for the committee and responsible for creating the QAPI culture, environment for change and facilitating quality assessment and performance improvement process. The executive director is responsible for selecting and appointing the committee members.

Required Members

- Executive Director serves as chairperson
- Clinical Manager
- Medical Director
- 3-5 members of the agency staff

Ad Hoc Teams

Ad hoc teams may be appointed by the QAPI Committee to participate in quality project. Team members are selected depending on the Performance Improvement Project (PIP) problem or issue identified.

Purpose of the Quality Assessment and Performance Improvement Committee

The QAPI Committee has 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 include:

- Identify trends in clinical outcomes
- Evaluation of data related to systems and services offered to patients
- Monitor new systems and services
- Monitor customer and patient satisfaction

A functional Quality Assessment and Performance Improvement (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 Committee

- The QAPI Committee meets monthly
- The chairperson selects a co-chair to act in the chairperson's absence and assists with the committee's work.
- Committee members are required to attend regularly scheduled meetings
- The committee focuses on significant areas of improvement each month
- The committee tracks progress of agencies performance improvement plans
- Confidentiality is maintained
- Only trended information, no patient specific information, is communicated outside the QAPI Committee
- Committee tracks and analyzes adverse patient events
- Agency staff are kept informed of PIPs and involved in QAPI process

Committee Agenda/Minutes

Attendance records are confirmed by signature section on monthly agenda/minutes. AIM statements and action plans are developed, reviewed and revised at each meeting. Follow-up to the prior month's plan is documented as well as a creation of a new plan for the current month.

The process for determining the agenda items for the monthly QAPI Committee meetings includes:

Review of Reports

- Discipline specific reports and quarterly peer audits
- Customer Concern Reports
- Safety Committee
- Infection Control
- PIP status and report
- Survey Reports
- Satisfaction Survey Results
- Outcome data
- HIS data

Performance Improvement

Performance improvement is an ongoing interdisciplinary process that is designed to improve the delivery of services and patient outcomes. The objective of performance improvement is continuous improvement through an ongoing evaluation of administrative, clinical, managerial and support process that most affect patient care.

The agency sets priorities to gain strategic view of its operating environment and to ensure the consistent quality of care provided over time. In addition to high volume, high risk areas, the agency tracks and analyzes adverse patient events, or pain and symptom control. The agency demonstrates how staff contributes to its quality improvement efforts.

Routine Measurement of Indicators

Indicator/Outcome	Sources of Data	Frequency of Measurement	Sample Size	Accountability
Patient & Family Centered Care				
Family willingness to refer	DEYTA	quarterly	100%	Executive Director
Overall Quality of Care	DEYTA	quarterly	100%	Executive Director
Response after hours/weekend	DEYTA	quarterly	100%	Executive Director
Bereavement POC meets family needs	Bereavement Records	quarterly	10%	Executive Director

Ethical Behavior and Consumer Rights				
Employees oriented to Ethics policy	Employee Files	On-hire	100%	Office Manager
Patient Eligibility	Admission and Recert documentation	Quarterly	10%	Clinical Supervisor
Clinical Excellence & Safety				
Pain assessment/management	Chart Audit	Quarterly	10%	Clinical Supervisor
Appropriate use of GIP	Chart Audit	Twice yearly	100%	Clinical Supervisor
Respite available for caregiver need	Chart Audit	Twice Yearly	100%	Clinical Supervisor
Continuous Care utilization	Chart Audit	Twice Yearly	100%	Clinical Supervisor
Evaluation of contracted Services	Contract Reviews	Annually	100%	Executive Director
Evaluation of adverse events	Incident Log	Each Event	100%	Executive Director
Organizational Excellence				
Governing Body achieves functions of hospice care	Governing Body Minutes	Annually	100%	Executive Director
Workforce Excellence				
Staff competency evaluated	Personnel Files	Annually	100%	Office Manager
Required in-services	Personnel Files	Annually	100%	Office Manager
All employees complete on-hire orientation	Personnel Files	Annually	100%	Office Manager
Compliance with Laws & Regulations				
Survey Readiness: mock survey	Chart Audits/ administrative records	Annually	10%	Executive Director/Clinical Director
CMS mandatory quality reporting: NQF measure	Chart Audits	Monthly	10%	Clinical Director
CMS mandatory quality reporting: Structural measure	QAPI plan approved by governing body	Annually		Executive Director
Stewardship & Accountability				
Met budget and financial goals set by Governing Body	Financials	Annually	100%	Executive Director
Performance Measurement				
Staff In-services provided on QAPI	In-service log	Annually	100%	Executive Director

QAPI planned carried out by Governing Body	QAPI minutes	Annually	100%	Executive Director

PLANNING FOR CHANGE: QAPI AND OUTCOME MEASURES

Quality improvement is not confined to patient care needs and extends beyond patient assessments to examine all components of the operation and how this affects the consistent quality of care over time.

An example of an agency specific quality indicator may be to assess the recruitment and retention of staff with minimal turn-over rates. By establishing this priority the agency could gain knowledge of its clinical operating environment and how it relates to patient outcomes. Implementing a PIP based on data collected will enable the agency to assess processes within the operation and the impact on patient care from a broader context.

EVALUATION OF THE QAPI PLAN

The QAPI committee reviews and revises Performance Improvement Plans {PIP's) each month to monitor on-going progress. Different patient care measures may require different data collection timeframes. The nature of the data element will determine the timeframe for collecting and updating the QAPI PIP plan. At a minimum the QAPI committee updates the on-going improvement projects quarterly. An impromptu meeting can be called at any time by a member of the team if a problem arises.

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ADMISSION CRITERIA AND PROCESS

Patient Services	Policy No.: 1003	Effective Date: 3/01/2019

SHALOM HOSPICE

PURPOSE

To establish standards and a process by which a patient can be evaluated and accepted for admission.

POLICY

Shalom Hospice will admit any patient with a life-limiting illness that meets the admission criteria.

> **MA State specific**: Limited life expectancy is defined as a prognosis of six (6) months or less life expectancy if the disease runs its normal course and is determined by the Hospice Medical Director and the patient's Attending Physician, if they have chosen one.

Patients will be accepted for care without discrimination on the basis of race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

> **FL State specific:** In no case shall a hospice patient be refused for admission or hospice services discontinued based on the inability of the patient to pay for such services.

Patients will be accepted for care based on need for hospice services. Consideration will be given to the adequacy and suitability of hospice personnel, resources to provide the required services, and a reasonable expectation that the patient's hospice care needs can be adequately met in the patient's place of residence.

Shalom Hospice's admission policy includes the review of the patient's primary insurance plan, such as Medicare, Medicaid, Managed Care, Private Insurance, Worker's Comp or other payment sources including private pay. Shalom Hospice's review process includes, but is not limited to, insurance verification of coverage, in-network vs. out-of-network requirements, authorization requirements, deductible amount met and unmet, co-pay, patient liability, and patient's ability to pay as determined by Shalom Hospice's Charity Care policy. See Fiscal Management Policy: Charity Care.

The patient's life-limiting illness and prognosis of six (6) months or less will be determined by utilizing standard clinical prognosis criteria developed by the Medicare Contractor's Local Coverage Determinations (LCDs).

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Shalom Hospice reserves the right not to accept any patient who does not meet the admission criteria, within the limitations of applicable law and regulations.

A patient will be referred to other resources if Shalom Hospice cannot meet his/her needs.

Once a patient is admitted to service, the organization will be responsible for providing care and services within its financial and service capabilities, mission, and applicable law and regulations.

Admission Criteria (See Patient Services Policy: Intake and Referral Process)

1. The patient must be under the care of a physician. The patient's physician (or other authorized independent practitioner) must order and approve the provision of hospice care, be willing to sign or have a representative who is willing to sign the death certificate, and be willing to discuss the patient's resuscitation status with the patient and family/caregiver.

2. The patient must identify a family member/caregiver or legal representative who agrees to be a primary support care person if and when needed. Persons without such an identified individual and who are independent in their activities of daily living (ADLs) will require a specific plan to be developed at time of admission with the social worker.

3. The patient must have a life-limiting illness with a life expectancy of six (6) months or less, as determined by the attending physician, if one has been chosen by the patient/legal representative, and hospice Medical Director, utilizing the standard clinical prognosis criteria found in the Local Coverage Determination guidelines approved by the Medicare Contractor in the region. Medicare-Administrative-Contractors/Who-are-the-MACs

4. The patient/legal representative must desire hospice services, and the focus of care desired must be palliative versus curative.

5. The patient and family/caregiver agree to the hospice plan of care, understand their right to participate in developing the plan of care and sign the consent form for hospice care.

6. The patient and family/caregiver agree that patient care will be provided primarily in the patient's residence, which could be his/her private home, a family member's home, a skilled nursing facility, or other living arrangements.

7. The physical facilities and equipment in the patient's home must be adequate for safe and effective care.

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8. The patient must reside within the geographical area that the organization services.
9. Eligibility for participation will not be based on the patient's race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.
10. If applicable, the patient must meet the eligibility criteria for Medicare, Medicaid, or private insurance hospice benefit reimbursement.
11. Eligibility criteria will be continually reviewed on an ongoing basis by the interdisciplinary team to assure appropriateness of hospice care.

PROCEDURE

1. The organization will utilize referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies, and physician offices in the determination of eligibility for admission to the program. If the request for service is not made by the patient's physician, he/she will be consulted prior to the evaluation visit/initiation of services.
2. The Clinical Manager / designee will assign hospice personnel to conduct initial assessments of eligibility for services within the time frame requested by the referral source or based on the information regarding the patient's condition or as ordered by the physician (or other authorized independent practitioner).

   WA State Specific:

   The Initial patient assessment will be completed by a registered nurse within seven calendar days of receiving and accepting a physician or practitioner referral for hospice services. Longer time frames are permitted when one or more of the following is documented:

   A. Longer time frame for completing the initial patient assessment is requested by physician or practitioner;

   B. Longer time frame for completing the initial patient assessment is requested by the patient, designated family member, or legal representative; or

   C. Initial patient assessment was delayed due to agency having challenges contacting the patient, designated family member, or legal representative.

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3. Assignment of appropriate hospice personnel to conduct the initial assessments of patient's eligibility for admission will be based on:

   A. Patient's geographical location

   B. Complexity of patient's hospice care needs/level of care required

   C. Hospice personnel's education and experience

   D. Hospice personnel's special training and/or competence to meet patient's needs

   E. Urgency of identified need for assessment

4. In the event that the time frame for assessment cannot be met, the patient's physician and the referral source, as well as the patient, will be notified for approval of the delay. A. Such notification and approval will be documented.

   B. If approval is not obtained for the delay, the patient will be referred to another hospice for services.

5. A hospice registered nurse will make an initial contact prior to the patient's hospital discharge, if possible or appropriate. The initial home visit will be made within the time frame requested by the referral source and according to organization policy, or as ordered by the physician (or other authorized independent practitioner).

   FL State Specific: The assessment process will be initiated within two hours and the admission to hospice expedited subject to having a physician order on hand and the patient/family selecting the hospice option.

   The purpose of the initial visit will be to:

   A. Explain the hospice philosophy of palliative care with the patient and family/caregiver as unit of care.

   B. Explain the patient's rights and responsibilities and grievance procedure. (See "Patient Rights".)

   C. Provide the patient with a copy of the organization's notice of privacy practices. "Patient/Family Orientation for Hospice Care" handbook.

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D. Assess the family/caregiver's ability to provide care.

E. Evaluate physical facilities and equipment in the patient's home to determine if they are safe and effective for care in the home.

F. Allow the patient and family/caregiver to ask questions and facilitate a decision for hospice services especially provided under the Medicare/Medicaid hospice benefit.

G. Review appropriate forms and subsequently sign forms by patient and family/caregiver once agreement for the hospice program has been decided.

H. Provide services as needed and ordered by physician (or other authorized independent practitioner), and incorporate additional needs into the hospice plan of care.

I. Give patient information about durable power of attorney for health care, if the patient has not already done so.

6. During the initial assessment visit, the admitting clinician will assess the patient's eligibility for hospice services according to the admission criteria and standard prognosis criteria to determine/confirm further:

   A. Level of services required and frequency criteria

   B. Eligibility (according to organization admission criteria)

   C. Source of payment

7. If eligibility criteria is met the patient and family/caregiver will be provided with a hospice brochure and various educational materials providing sufficient information on:

   A. Nature and goals of care and/or service

   B. Hours during which care or service are available (physician, nursing, drugs and biological are available 24 hours/day. All other services are available to meet individual patient care needs)

   C. Access to care after hours

   D. Costs to be borne by the patient, if any, for care

E. Hospice mission, objectives, and scope of care provided directly and those provided through contractual agreement

F. Safety information

G. Infection control information

H. Emergency preparedness plans

I. Available community resources

J. Complaint/grievance process

K. Advance Directives

L. Availability of spiritual counseling in accordance with religious preference

M. Hospice personnel to be involved in care

N. Mechanism for notifying the patient and family/caregiver of changes in care and any related liability for payment as a result of those changes

8. The hospice registered nurse will document that the above information has been furnished to the patient and family/caregiver and any information not understood by the patient and family/caregiver.

9. The patient and family/caregiver, after review, will be given the opportunity to either accept or refuse services.

10. The patient or his/her representative will sign the required forms indicating election of hospice care and receipt of patient rights and privacy information.

11. Refusal of services will be documented in the clinical record. Notification of the Clinical Supervisor, attending physician, and referral source will be completed and documented in the clinical record.

12. The hospice registered nurse will assist the family in understanding changes in the patient's status related to the progression of an end-stage disease.

13. The hospice registered nurse will provide training to the family or caregiver(s) in techniques for providing care.

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14. The hospice registered nurse will contact the physician for clinical information in writing to certify patient for hospice care.

15. The hospice registered nurse will complete an initial assessment during this visit within 48 hours after the election of the hospice care (unless the physician, patient or representative requests that the initial assessment be completed in less than 48 hours.) (See "Initial Assessment")

16. The hospice registered nurse will contact at least one (1) other member of the interdisciplinary group for input into the plan of care, prior to the delivery of care. The two

    (2) remaining core services must be contacted and provide input into the plan of care within two (2) days of start of care; this may be in person or by phone.

17. If the patient is accepted for hospice care, a comprehensive assessment of the patient will be performed no later than 5 calendar days after the election of hospice care. A plan of care will be developed by the Interdisciplinary Group, including the Medical Director / Physician designee and Attending physician, if any, and submitted to the attending physician for signature. The patient's wishes/desires will be considered and respected in the development of the plan of care. (See Patient Service Policies: Initial Assessment; Comprehensive Assessment)

18. The time frames will apply for weekends and holidays, as well as weekday admissions.

19. A clinical record will be initiated for each patient admitted for hospice services in the electronic record system.

20. If a patient does not meet the admission criteria or cannot be cared for by Shalom Hospice, the Intake/Referral Manager and Clinical Director should be notified and appropriate referrals to other sources of care made on behalf of the patient. In addition, a timeframe for followup will be established, as needed.

21. The following individuals should be notified of non-admits:

    A. Patient

    B. Physician

    C. Referral source (if not physician)

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22. A record of non-admits will be kept for statistical purposes, with date of referral, date of assessment, patient name, services required, physician, reason for non-admit, referral to other hospice care facilities, etc.

23. Exceptions will not be granted for admission when the patient does not meet LCD guidelines or does not have a life limiting illness. In other instances, if the patient does not meet the stated criteria for admission to the program, exceptions will be decided upon by the Executive Director/Administrator after consulting with the Compliance Officer, as well as the Clinical Director and/or the Medical Director upon request of the referring party and/or the patient.

24. In instances where continued care to a patient contradicts the recommendations of an external or internal entity performing a utilization review, the Executive Director/Administrator will be notified. All care, service, and discharge decisions must be made in response to the care required by the patient, in compliance with regulations, regardless of the external or internal organization's recommendation. The patient and family/caregiver, as appropriate, attending physician and Medical Director will be involved in deliberations about the denial of care or conflict about care decisions.

25. A record of conflict of care issues and outcomes will be kept for statistical purposes, referencing the date of the conflict of care issue, the patient name, the external or internal organization recommendations and reasons, and complete documentation of organization decision and patient care needs.

ADMISSION CRITERIA AND PROCESS	**Policy Number:**
CHAP Standard(s): HPFC 9.D	
Federal Regulatory Citation:	
State/Local Regulatory Citation: MA 105 CMR 141.208 (C); WAC 246-335-620; FAC 59A-38.004(3)(a)11	
Dates Reviewed/Revised: 3/1/2019; 5/29/2019; 9/1/2019; 10/1/2019; 4/30/2020; 5/1/2020	

Bereavement Assessment

Patient Services	Policy No.:	Effective Date: 1008

SHALOM HOSPICE

PURPOSE

To provide guidance for the assessment and reassessment of the bereavement needs of families/caregivers.

POLICY

Shalom Hospice will provide bereavement services for 13 months after the patient's death to surviving family/caregiver members.

The bereavement plan of care is developed based on an assessment of the patient/family needs at the time of admission and during the provision of hospice care and when the patient dies. (See Patient Services Policy "Bereavement Services")

PROCEDURE

1. On admission, the registered nurse or social worker will complete an Initial bereavement assessment of patient family's needs focusing on social, spiritual and cultural factors impacting ability to cope with patient's death that is documented in the electronic record and available to the Bereavement Coordinator. At a minimum, it will include:
   A. Patient/family grief and/or loss issues
   B. Survivor needs
   C. Social, spiritual, and cultural issues
   D. Services to be provided
   E. Referrals to be made
   F. Grief risk factors
   G. Potential for pathological grief reactions
   H. Individual counseling, support groups, letters and cards
2. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.

Bereavement Assessment		
Patient Services	Policy No.:	Effective Date: 1008

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3. The Bereavement Coordinator will review the bereavement risk assessment to determine potential needs of the survivors.
2. After the death occurs, the hospice social worker or Bereavement Coordinator will complete the bereavement follow-up assessment.
3. The Bereavement Coordinator will develop a plan for intervention based on the findings of the bereavement follow-up assessment.
4. The Bereavement Coordinator or Volunteer will document the family bereavement interventions.
5. Upon completion all bereavement documentation will be filed.

BEREAVEMENT ASSESSMENT	Policy Number:
CHAP Standard(s): HCPC 13.1	
Federal Regulatory Citation: 418.54(c)(7).	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 03/01/2019; 09/26/2019; 10/1/2019	

SHALOM HOSPICE

BEREAVEMENT SERVICES	Effective: 3/1/2019
Patient Services	Policy No.: 1009

PURPOSE

To ensure that appropriate and coordinated bereavement services are provided to families/caregivers.

POLICY

Shalom Hospice will provide an organized bereavement program supervised by a qualified Bereavement Coordinator for at least (1) year following the death of the patient. Bereavement services will be under the direction and supervision of a person qualified by training and experience for the development, implementation and assessment of a plan of care to meet the needs of the bereaved and provided by personnel who have received training and have experience in dealing with grief. The duties and responsibilities of the Bereavement Coordinator and Bereavement Counselors will be specified in appropriate job descriptions.

The program will provide bereavement services to the families/caregivers of hospice patients both before and after the patient's death in accordance with the plan of care. The purpose of these services will be to facilitate a normal grieving process and to identify and appropriately refer those persons who may be experiencing pathological grief reactions that may interfere with the eventual resolution and integration of their losses. Bereavement services will provide support to enable an individual/family to adjust to experiences associated with death and to prepare the individual to function independently of hospice by identifying a support system for the individual or family.

Bereavement services will be coordinated, insofar as possible, with the individual's clergy, if any, as well as with other community resources judged to be useful and beneficial to the family/caregiver.

PROCEDURE

1. A bereavement risk assessment will be completed by the hospice social worker at the time of admission to hospice. (See "Bereavement Assessment".) Information gathered will be incorporated into the plan of care and considered in the bereavement plan of care.

2. After the bereavement risk assessment is completed, a plan will be developed to address bereavement/grief issues and will be implemented as needed.

3. Depending on the patient and family/caregiver needs identified in the bereavement assessment, bereavement counselors may need to contact and/or visit the patient and family/caregiver prior to the death.

4. The bereavement counselors may provide supportive counseling to the patient and family/caregiver prior to the death.

5. After a death has occurred, the bereavement assessment will be updated and the family/caregiver needs will be discussed at the next interdisciplinary group meeting.

6. Bereavement interventions will be reflective of the family/caregiver's choices to participate in the bereavement program.

7. Families/caregivers who choose to participate in the bereavement will be accorded the same confidentiality and privacy rights as a hospice patient.

8. Within two (2) weeks after the death of a patient, a sympathy card will be sent to the bereaved.

9. After three (3) weeks, a bereavement letter will be sent to the bereaved giving support and outlining the hospice bereavement services.

10. Within three (3) to five (5) weeks after the patient's death, a bereavement assessment (see "Bereavement Assessment" Policy) will be completed by the bereavement counselor following the family/caregiver. This assessment will note and observe the bereaved for symptoms related to grief. The bereavement counselor will render a professional judgment as to whether the bereaved is experiencing normal grief, moderate grief, or a severe grief reaction.

11. If a person is noted as experiencing normal grief, the bereavement counselor will make contact with the bereaved person for ongoing assessment and support at three (3), six (6), and nine (9) months after the patient's death and at the anniversary of the patient's death. The bereavement counselor will make information available to the bereaved person regarding bereavement support groups, other support groups available in the community, and the availability of individual counseling by the hospice personnel.

12. In addition to the services outlined above, persons deemed to be experiencing moderate or severe grief 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. The Bereavement Coordinator will evaluate each bereaved on a case-by-case basis and evaluate the need for individual counseling. If necessary, the bereavement, spiritual care, or social work hospice personnel will provide individual counseling to the bereaved. Referrals to outside professionals may also be required.

    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 supervision of the Bereavement Coordinator.

13. A bereavement file may be maintained on each family/caregiver unit of care, in addition to the electronic health record. Together, the complete file will contain the following information:

    A. Copy of the patient referral and initial bereavement assessment

B. Bereavement service report

C. All bereavement assessments made

D. A bereavement plan of care

E. All bereavement clinical notes that have been written and/or letters sent to the bereaved

14. Ongoing bereavement contact will be concluded at the end of up to one (1) year, if the bereaved is no longer in need of hospice bereavement services.

A. A letter will be sent indicating completion of bereavement services.

B. A copy of the letter will be placed in the bereavement file and the file retained.

15. If at up to one (1) year, grieving is still perceived as acute, the Bereavement Coordinator will attempt to reassess what additional professional services may be necessary and make appropriate referrals as indicated.

16. Bereavement assessment and clinical notes will be submitted to the patient's permanent clinical record.

BEREAVEMENT SERVICES	**Policy Number:**
CHAP Standard(s):	
Federal Regulatory Citation:	
State/Local Regulatory Citation: 105 CMR 141.204 (G) (3)	
Dates Reviewed/Revised: 3/1/2019	

SHALOM HOSPICE

COMPREHENSIVE ASSESSMENT	Effective: 3/1/2019
Patient Services	Policy No.: 1013

PURPOSE

To provide guidelines for the comprehensive assessment.

POLICY

A comprehensive patient assessment will be performed by the interdisciplinary group no later than 5 calendar days after the election of hospice care in consultation with attending physician.

PROCEDURE

1. During the comprehensive patient assessment, all baseline data and other relevant information will be documented in the patient's clinical record, including at least the following information, as relevant:

   A. An assessment of pain, including the origin, location, duration, severity, and relief measures (See "Pain Assessment" Policy No. 1-018)

   B. An assessment of severity of secondary symptoms, such as nausea, vomiting, respiratory distress, and nutritional status (See "Nutritional Assessment" Policy No. 1-017)

   C. Nature and condition causing admission (including the presence or lack of objective data and subjective complaints)

   D. Alleviating and exacerbating factors for physical symptoms

   E. Current treatment and patient response to that treatment

   F. An assessment of the patient's response to palliative treatment

   G. A physical assessment, including blood pressure, temperature, pulse, respiration, skin, and other relevant data related to pertinent physical findings and the patient's terminal illness

   H. Imminence of death

   I. Patient's functional status including, but not limited to, the degree of self-care and the amount and level of assistance needed (See "Functional Assessment" Policy)

   J. Complication and risk factors that affect care planning

   K. Patient's past and present medical and psychosocial history including pertinent diagnosis and any co-morbid conditions

L. Name and address of the patient's attending physician

M. Name of the hospital and other agencies or persons involved in the past and present care of the patient

N. An evaluation of the home environment and assessment of emergency preparedness of the patient.

O. Presence of any Advance Directives for care and/or discussions with patient and family/caregiver regarding the withholding of resuscitative services or the withdrawal of life-sustaining treatment

P. Equipment presently in home and potentially needed by patient

Q. Review of current and related past medications, including prescription and over-the-counter medications, allergy history and other medication information, including but not limited to identification of the following:

1. Effectiveness drug therapy
2. Unwanted side and toxic effects
3. Drug interactions (actual or potential)
4. Duplicate drug therapy
5. Drug therapy currently associated with laboratory monitoring
6. Whether the medication is unrelated to the terminal illness or related conditions (ensure that there is clinical documentation to support unrelatedness)

R. Patient and family/caregiver support systems and the care the family/caregiver is available, capable, and willing to provide, including applicable strengths of patient, physical, psychosocial, and/or spiritual resources available

S. The patient's psychosocial status, including emotional barriers to treatment, cognitive limitations, memory and orientation, family relationships, social history, source and adequacy of environmental and other resources, coping mechanisms, and the patient's and family/caregiver's reaction to illness.

T. An assessment of the patient's and family/caregiver's spiritual orientation, including, as appropriate, any involvement in a religious group such as a church or synagogue or a support group such as Alcoholics Anonymous and spiritual concerns or needs such as despair, suffering, guilt, etc.

U. Involvement of family/caregiver, neighbors, and/or other individuals/organizations, including involvement in any support groups

V. An assessment of the need for volunteer services to offer support or respite to the patient and family/caregiver

W. A bereavement assessment of the needs of the patient's family and other individuals focusing on:

1. The nature of the relationship to the patient
2. Circumstances surrounding the illness/prognosis
3. Behaviors prior to and after the illness/prognosis
4. Survivor needs (social, spiritual and cultural) that may impact coping skills
5. Potential for pathological grief reactions

X. Laboratory results

Y. Medical, alcohol, and other drug history

Z. TB screening

AA. Specific, individualized patient needs/problems pertinent to the hospice care being provided

BB. Past medical and surgical care, including dates of onset/exacerbation

CC. The patient's and family/caregiver's educational needs, abilities, motivation, and readiness to learn

DD. The need for referrals and further evaluation by appropriate health professionals

2. The assessment should determine:

   A. Probable prognosis of six (6) months or less

   B. Patient problems and needs related to the terminal illness

   C. Patient goals related to the terminal illness

   D. Type of services, frequency, and duration needed to meet patient care needs

   E. Anticipated discharge needs, including bereavement and funeral needs

   F. Survival risk factors, such as the nature of the relationship with the patient, circumstances surrounding the death, behaviors before and after the death, and availability of coping mechanisms and potential for pathological grief reactions

   G. The need for an alternative level of care

3. The organization must assure that the uniform data elements allow for measurement of outcomes and include hospice and palliative care aspects.

4. The Clinical Manager will be responsible for assuring that the documentation of clinical findings supports the terminal diagnosis.

5. The comprehensive assessment is updated by the interdisciplinary group as frequently as the patient's condition requires but at a minimum every 15 days.

A. The interdisciplinary group is required to only update those sections that require updating

B. If no changes are needed, then that must be documented

C. If there has been a change in the patient's condition/status, then the comprehensive assessment must be updated

COMPREHENSIVE ASSESSMENT	Policy Number:
CHAP Standard(s): HII.4c, HII.4f	
Federal Regulatory Citation: 418.54(b), (c), (e)	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 3/1/2019	

SHALOM HOSPICE	CONTINUOUS CARE SERVICES	Effective: 3/1/2019
	Patient Services	Policy No.: 1014

PURPOSE

To establish the criteria and procedures for providing continuous care services to patients.

POLICY

Continuous care will be available to patients on the Medicare or Medicaid hospice benefits, or as other payers allow. Continuous care level of care must be provided a minimum of eight (8) hours or as much as 24 hours a day during periods in which an individual patient and family/caregiver require continuous nursing care to achieve palliation or to manage acute medical symptoms, in order to maintain the patient in his/her residence. The majority of care (51% of hours provided) needs to be licensed nursing care; other disciplines may be used to complete the time needed. Volunteers may be utilized, but their hours are not billable.

Definitions

1. Continuous Care: A short-term intervention for a medical crisis. The need for continuous care and the skill level of hospice personnel needed in the home will be evaluated daily by the hospice Case Manager or designee and clearly documented in the patient care notes and plan of care.

2. Crisis situations that may require continuous care include, but are not limited to, the following:

   A. Uncontrolled, severe symptoms, e.g., pain, dyspnea, nausea and vomiting, which require continuous skilled assessment, intervention, and evaluation

   B. When a function necessary for safe medical management must be performed and monitored continuously and/or closely, e.g., IV-related function[1]

   C. If the patient meets criteria for an acute inpatient admission but cannot or will not agree to be moved

   D. Seizures

   E. Hemorrhaging

   F. Highly unstable vital signs, e.g., diabetic management

   G. Severe anxiety, agitation, or confusion that poses a safety threat

   H. Suicidal ideation or related action

   I. Delirium

PROCEDURE

1. This benefit is covered under Medicare/Medicaid and some private insurance programs. Verification of ability to pay must be made for all private pay and insurance patients **PRIOR** to instituting continuous care services.

2. The hospice registered nurse or Case Manager will assess whether the patient and family/caregiver's condition requires continuous care.

   A. The hospice registered nurse confirms this assessment with the hospice Clinical Supervisor or designee.

   B. During non-business hours, the on-call nurse may initiate continuous care.

   C. The hospice personnel request and clinical eligibility will be reviewed immediately by the Clinical Supervisor when normal business operations resume.

   D. The Case Manager will inform all members of the interdisciplinary group of patient's change in level of care.

3. After the hospice registered nurse confirms the need and appropriateness of continuous care with the hospice Clinical Supervisor or designee, the hospice registered nurse will contact the attending physician and/or hospice Medical Director.

   A. The hospice registered nurse will report to the attending physician and/or Medical Director the patient's condition, nursing assessment, and any other relevant information.

   B. The hospice registered nurse will document the attending physician's (or other authorized independent practitioner's) or Medical Director's orders in the plan of care. The physician's (or other authorized independent practitioner's) orders will include the order for continuous care. This will be documented as a verbal order.

4. Continuous care will be provided by qualified personnel under the supervision of the hospice registered nurse. Contracted agencies may be used to supplement the services provided by hospice only in periods of staffing crisis when hospice has demonstrated a good faith attempt to staff continuous care hours with core nursing employees.

   A. Orientation sessions will be presented by the hospice Clinical Supervisor or designee to personnel providing continuous care services. Orientation will include discussion of hospice philosophy and goals, hospice expectations, and specific hospice nursing guidelines.

   B. Continuous care personnel will be advised that they must work the entire shift for which they are scheduled and must fill in the continuous care log. If a need to leave earlier arises, they must call the hospice registered nurse or the on-call nurse for approval.

5. The hospice registered nurse, in conjunction with the hospice Clinical Supervisor or designee, will determine the level of skill needed for continuous care. Hospice registered

nurses, licensed practical/vocational nurses, and/or other disciplines may be utilized to provide this service.

A. The patient's predominant need must be for skilled nursing intervention. (51% of continuous care hours must be nursing.)

B. A minimum of eight (8) hours of care must be provided during a 24-hour day, which begins and ends at midnight. This care need not be continuous; that is, four (4) hours could be provided in the morning and another four (4) hours provided in the evening of that same day. Fifty-one percent (51%) of this skilled care must be provided by a nurse.

6. For a registered or licensed practical/vocational nurse to be eligible to provide continuous care, that person must have a current license to practice nursing in Shalom Hospice's state and must have completed the hospice orientation session. Hospice personal care aides and contract hospice aides must also have current certification from the state or equivalent and have completed the hospice orientation session. The responsible Clinical Supervisor or designee will determine the appropriateness of nurses and other professionals assigned to provide continuous care according to individual patient and family/caregiver requirements and will reassign correct level of personnel as necessary.

7. The initial report of the patient and family/caregiver condition will be given by the hospice registered nurse or hospice Clinical Supervisor or designee to the nurse or contract person providing continuous care. Shift-to-shift report will be the responsibility of the individuals providing continuous care.

8. A continuous care packet will be delivered to the home of the patient prior to or as soon as possible after continuous care is instituted. The packet will include information regarding:

A. "Responsibilities of Continuous Care Personnel"

B. "Charting Guidelines for Continuous Care"

C. Continuous Care Orders—The hospice registered nurse will specify all current physician's (or other authorized independent practitioner's) orders. The original copy will be taken to the hospice office to be signed by the attending physician and become part of the patient's clinical record. The hospice registered nurse will make a duplicate copy that will remain in the continuous care packet as a reference for the continuous care personnel. The following will be included in the physician's (or other authorized independent practitioner's) orders:

1. Initiate continuous care supervised by hospice registered nurse

2. Assess patient's physical condition and document results

3. Assess pain and titrate medication to affect maximum comfort level and document results

4. Provide counseling and emotional support to family/caregiver

5. Do not resuscitate, as appropriate

6. Specific medical orders

7. Physician to be notified of changes in condition by hospice registered nurse

8. Staff sign log—all staff must sign in (date, name, time in and out) for billing purposes

D. Continuous Care Plan—The hospice registered nurse will be responsible for initiating the continuous care plan prior to providing service. Any change in the continuous care plan must be approved by the hospice registered nurse to assure continuity of care.

E. Continuous Care Documentation Forms—Hospice and/or contract nursing personnel will document in the clinical record not less than hourly on continuous care notes. The documentation will include, but not be limited to:

1. The patient's and family/caregiver's physical or emotional status, counseling, teaching, skilled nursing care, and any medication given

2. Any acute change that necessitates notifying the hospice Case Manager

3. At a minimum, hourly entries of skilled nursing care

a. The first entry must be made in the starting hour of the shift

b. Continuous Care is reported and billed to Medicare in 15 minute "units", although this does not constitute a need for 15 minute documentation

c. The last entry must be made in the final hour of the shift.

d. Direct patient care would end when patient expires. The time between expiration and pronouncement and/or funeral home arrival would not apply for continuous home care hours.

9. The Case Manager will make daily evaluations to determine if continuous care is warranted. The Case Manager will document supervisory visits in the continuous care notes. Supervision of continuous care includes:

A. A report from in-home nursing personnel

B. Assessment of the patient and family/caregiver by hospice Case Manager

C. Review of documentation by the hospice Case Manager with continuous care nursing personnel

D. Review of medications—administration and titration

E. Review of new or revised physician's (or other authorized independent practitioner's) orders

10. Continuous care personnel must notify the hospice Case Manager of any acute change in the patient and family/caregiver status necessitating nursing or medical intervention.

11. The hospice Case Manager will coordinate with the attending physician and hospice Medical Director any changes in medical treatment and the plan of care. The hospice Case Manager will document physician contacts in the patient's clinical record.

12. The hospice Case Manager will be responsible for contacting the attending physician to obtain changes in medical orders.

    A. The hospice Case Manager will notify the continuous care personnel of changes in medical and/or nursing orders.

    B. The orders will be documented with date and time by in-home nursing personnel on continuous care orders form.

    C. The hospice Case Manager will obtain any needed equipment or medications and for approving pharmacy charges according to hospice policies and procedures.

13. The hospice Case Manager will closely review the documentation of all personnel providing continuous care to assure that the level of skill is documented.

14. The hospice Case Manager will be responsible for ensuring that all forms completed by continuous care personnel become part of the patient's permanent clinical record. The hospice Case Manager will assure that all patient care clinical notes will be picked up and returned to the hospice office.

15. When the decision is made to institute continuous care, the Case Manager and social worker will begin assisting the family/caregiver in planning for care when continuous care is no longer needed or appropriate.

16. The hospice Case Manager or designee will determine, along with the attending physician and hospice Medical Director, when continuous care is no longer needed and notify interdisciplinary group members to resume routine home care plan of care.

CONTINUOUS CARE SERVICES	**Policy Number:**
CHAP Standard(s): HII.1b,HII.2a6	
Federal Regulatory Citation: 418.56(b), (c), (d), (e), 418.64, 418.70, 418.72, 418.108	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 3/1/2019	

SHALOM HOSPICE

COORDINATION OF SERVICES	Effective: 3/1/2019
	Policy No.:
Patient Services	1015

PURPOSE:

To ensure the coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services.

POLICY STATEMENT:

Each patient will be assigned an RN Case Manager upon admission by the Clinical Director/Director of Patient Care Services or Clinical Supervisor. It will be the responsibility of the RN Case Manager to facilitate communication about changes in the patient status among assigned personnel.

Timely and ongoing communication is the responsibility of each team member and will be appropriate to the needs and abilities of the patient, and relevant to the care/service provided. The clinician/technician will be responsible for facilitating communications about changes in the patient's status among the assigned personnel.

PROCEDURE:

1. The program supervisor will assign the patient to an RN Case Manager based on the patient's need and level of care required, geographic area, and qualifications of organization personnel needed.
   A. A registered nurse will be assigned to a patient receiving hospice care.
2. The assigned clinician will be qualified through education, training, and/or experience and will:
   A. Understand the principles of care/service provided
   B. Know the required qualifications for organization personnel providing care/service and know which organization personnel possess these qualifications
   C. Know the scope of care/service that can be provided by various organization personnel
   D. Understand the nature of the patient population served
3. The name of the RN Case Manager will be clearly documented in the clinical record.
4. Care coordination will include, but not be limited to:
   A. Clearly outlining each clinician's responsibilities to avoid duplication of services
   B. Developing complementary actions and goals
   C. Regularly occurring telephone or email communication among team members
   D. Planned face-to-face conferences

E. Timely documentation of coordination of care activities

F. Appropriate involvement of the patient and caregivers

G. Limiting the number of personnel assigned to a case, when possible

H. Proper communication upon "hand-off" of patient, including the opportunity for questions between the giver and receiver of patient information

I. Integration of services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines.

J. Coordination of care delivery to meet the patient's needs, and involve the patient representative, and caregivers, as appropriate, in the coordination of care activities

K. Ensuring that each patient, and their caregiver(s), where applicable, receive ongoing education and training provided by the organization regarding the care and services identified in the plan of care. The organization shall provide training, as necessary, to ensure a timely discharge, if applicable.

5. It will be the responsibility of the primary clinician to facilitate communication about changes in the patient's status among all assigned disciplines.

6. Organization personnel will communicate changes in a timely manner via telephone, one on-one meetings, case conferences, and home visits. Documentation of all communications will be included in the clinical record on a communication note, case conference summary, or clinical note. Documentation will include: the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication.

7. When the patient requires more than one (1) service from the organization, the Case Manager will be responsible for cooperative care planning in order to assure that goals, actions, and the interrelationship of services is not duplicated and to minimize the potential for missed or conflicting services.

8. **NH State Specific:** If, on a temporary basis, not to exceed 90 days, Shalom Hospice is unable to provide any of the core care and services, Shalom Hospice will have a written agreement with another agency to provide the required services.

9. Written evidence of care coordination may be found in the plan of care/service, case conference summary forms, clinical notes in the patient's clinical record or interdisciplinary group meeting notes.

10. All organization personnel involved in patient care/service, including those providing contracted services, will have access to the plan of care/service and all other relevant patient information to ensure coordination and continuity. All personnel will be knowledgeable regarding patient needs, goals of care, and services.

11. Contract organization personnel will participate in preparation of the plan of care/service; submit weekly documentation of services provided including clinical notes, schedule of visits, and patient evaluations/assessments; and participate in multidisciplinary (interdisciplinary group) case conferences when a patient in their caseload is being discussed.
12. **NJ Specific**- The Director of Clinical Services will to their best to provide continuity of care by the same health care practitioner whenever possible.

COORDINATION OF SERVICES	Policy Number:
CHAP Standard(s): HCPC 19.I, 23.D; HSLG 14.D	
Federal Regulatory Citation: 418.56(a), (e)	
State/Local Regulatory Citation: He-P 823.15 (b)	
Dates Reviewed/Revised: 3/1/2019; 10/1/2019	

SHALOM HOSPICE

INPATIENT SERVICES (General Inpatient and Respite)	Effective: 3/1/2019
Patient Services	Policy No.: 1030

PURPOSE

To establish the guidelines for providing inpatient services and to establish the criteria for admitting a patient for general inpatient care or respite care services.

POLICY

The total number of inpatient days used by Medicare beneficiaries who elect hospice coverage in any 12-month period will not exceed 20% of the total number of hospice days for this group of beneficiaries.

General inpatient care and 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.

Hospice personnel will be available 24 hours a day for clinical consultation to the inpatient personnel

The inpatient facility will meet the following criteria:

A. Is a contracted Medicare and/or Medicaid-certified hospital or skilled facility

B. Provide 24-hour nursing services including:

   1. Sufficient staffing to meet the patient's total nursing needs

   2. Provision of care in accordance with the patient's plan of care established by hospice for treatments, medications, and diet as prescribed

   3. A focus on insuring that the patient is kept comfortable, clean, well groomed, and protected from accident, injury, and infection

   4. Each shift at the facility being staffed with a registered nurse who provides direct patient care (24-hour RN not required for respite care)

C. Has an acceptable disaster preparedness plan

D. Meets all federal, state, and local health and safety regulations

E. Provides storage for emergency medications, including a locked compartment for Schedule II drugs. The RN is to have access to the keys of this compartment at all times, and will document any usage from this compartment at time of administration, and for reconciliation

F. Provides accountability for all drugs, including disposal of controlled substances. A reconciliation log and documentation of disposal will be completed by the RN and the pharmacist.

G. Has patient and family/caregiver areas and services that accommodate the hospice philosophy of care including, but not limited to:

1. Unlimited and private contact with visitors, including small children, at any hour
2. Accommodations for overnight stays with patient
3. Privacy provided for family after patient's death
4. Ability to keep and use personal clothing and possessions (unless medically contraindicated or infringes on other patients' rights)
5. A homelike environment, which supports patient dignity and positive self-image
6. Menus that are planned and posted in advance with food safely and accurately prepared and served to meet individual nutritional needs
7. Laundry management and housekeeping practices that are designed to maintain a sanitary and comfortable environment and to prevent the spread of infection

H. Has policies and procedures consistent with hospice and agrees to abide by the patient care protocols established by the hospice for its patients

I. Agrees to abide by patient care protocols established by hospice including post-mortem procedures as defined by hospice

2. The inpatient provider will be furnished a copy of the patient's plan of care that will specify the inpatient services to be provided.

3. The clinical record includes documentation of all inpatient services and events, and a discharge summary.

4. A copy of the clinical record will be made available to the hospice upon request.

5. Inpatient services will be provided in accordance with a written agreement designating the parties responsible for the implementation of the provisions of the agreement. (See Policy "Written Agreements for Contracted Services"

6. Hospice will provide appropriate training and education for inpatient personnel.

7. Admission and discharge from inpatient services will be the responsibility of the hospice Case Manager.

A. Physician (or other authorized independent practitioner) order will be obtained to change the level of care.

B. All interdisciplinary group members will be notified of the change.

C. Hospice will be responsible for coordination of the patient's transfer into and out of the inpatient level of care.

GENERAL GUIDELINES

1. General Inpatient Care is indicated when:

General inpatient care level of care is a short-term level of care for care that cannot feasibly be provided at home. The key is the patient's medical condition. It is not intended as a solution to a negligent or absent caregiver.

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 interdisciplinary group and in consultation with the patient's attending physician, if the patient has chosen one.

A. Pain control that is unable to be managed appropriately in the home setting

B. Other Symptoms

1. Rapid decline related to varied factors, such as bleeding, that are inconsistent with home management.

2. Fluctuating/deteriorating mental status, psychosis, severe confusion and/or combativeness necessitating titration of medications, change in environment, or consultation and intervention by psychologist or psychiatrist.

3. Severe shortness of breath or respiratory distress that creates an unmanageable situation for patient and family/caregiver in home care setting.

4. Intractable nausea or vomiting.

5. Open lesions requiring frequent professional care (decubiti, malignant ulcerations, burns, severe abrasions or fistulas—at least b.i.d. dressing changes).

6. Other complicated care—frequent nasotracheal suctioning or GI suctioning, frequent parenteral injections, management of draining fistulas.

7. 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 reaccumulating ascites or pleural effusion requiring recurrent tapping, recurrent aspiration.

8. Other presenting problems may be identified and evaluated on an individual basis.

C. Psychosocial Pathology

1. Evaluation of disturbed mental status, e.g., hallucinations, delusions, paranoia, excessive agitation, combativeness, requiring intensive monitoring

2. Depression, anxiety in the extreme—suicidal ideation, euthanasia, assisted suicide ideation, extreme withdrawal, including inadequate P.O. intake

D. Clinical indications for continued stay at the general inpatient level of care:

One or more of the clinical criteria identified above must be present in order for the patient to be considered appropriate for continued general inpatient care. Decisions for continued inpatient stay will be made on an individual case-by-case basis after evaluation by the interdisciplinary group including the hospice Medical Director and in consultation with the patient's attending physician. Patients will not be routinely discharged if they need continued inpatient care.

2. Respite care is indicated when:

A. The family/caregiver is unable to continue managing the patient's physical, emotional, or psychological needs and requires a break for one (1) to five (5) days.

B. Injury or impairment to the family/caregiver creates a need for respite to provide the family/caregiver and the interdisciplinary group an opportunity to problem solve.

C. 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 (5) days.

D. Rest or relief is required by the family/caregiver in order to maintain this individual at home.

PROCEDURE

Procedures for admissions for inpatient care are developed to meet the needs of specific contracted inpatient units. The Clinical Director is responsible for maintaining and communicating these procedures.

INPATIENT SERVICES	Policy Number:
CHAP Standard(s): HI.5c, HII.7,HII.9, HI.5c, d, HII.2a7,	
Federal Regulatory Citation: 418.108(b), (c), (d), 418.110	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 2/28/2019	

1. Evaluation of disturbed mental status, e.g., hallucinations, delusions, paranoia, excessive agitation, combativeness, requiring intensive monitoring

2. Depression, anxiety in the extreme—suicidal ideation, euthanasia, assisted suicide ideation, extreme withdrawal, including inadequate P.O. intake

D. Clinical indications for continued stay at the general inpatient level of care:

One or more of the clinical criteria identified above must be present in order for the patient to be considered appropriate for continued general inpatient care. Decisions for continued inpatient stay will be made on an individual case-by-case basis after evaluation by the interdisciplinary group including the hospice Medical Director and in consultation with the patient's attending physician. Patients will not be routinely discharged if they need continued inpatient care.

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CHAP Standard(s): HI.5c, HII.7,HII.9, HI.5c, d, HII.2a7,	
Federal Regulatory Citation: 418.108(b), (c), (d), 418.110	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 2/28/2019	

SHALOM HOSPICE

INTAKE AND REFERRAL PROCESS	Effective: 3/1/2019
Patient Services	~~Policy No.:~~ 1031

PURPOSE

To establish the process for acceptance and entry of patients into hospice.

POLICY

Referrals will be accepted 24 hours a day, seven (7) days per week. Personnel will be available 24 hours a day to accept patients into hospice.

Shalom Hospice will accept only those patients whose needs can be met by the services it provides and who meet the hospice admission criteria.

> **FL State Specific**: In no case shall Shalom Hospice refuse or discontinue hospice services based on the inability of the patient to pay for such services.
>
> Referral response time will be no longer than one hour.

PROCEDURE

1. Hospice referrals will be documented in the electronic health record and/or an intake form
2. Referrals for hospice services may be accepted by clinicians, including the Executive Director/Administrator, Clinical Director/Manager, nurses, social worker, Intake/Referral Manager or others, as deemed appropriate by the Executive Director/Administrator.
3. Referral information may be accepted by any of the following methods:
   A. Telephone
   B. Facsimile
   C. Written order
4. Referrals may be accepted from any of the following individuals:
   A. Any licensed practitioner, including physicians, nurse practitioners, physician's assistants or their office staff
   B. Discharge planners from inpatient and/or outpatient services
   C. Social service agencies
   D. Individual patients and/or families/caregivers and loved ones
   E. Case Managers and/or insurance company representative
   F. Home health agencies
   G. Other hospice organizations
   H. Skilled Nursing, Assisted Living, or other community living facilities

I. Other healthcare providers

5. During scheduled business hours calls, referral calls will be transferred to the intake department.

   A. Intake personnel will receive information regarding patient demographics, including name, age, birthdate, diagnosis, services needed, medications, attending physician (or other authorized independent practitioner), referral source, hospitalization, etc., in order to make the initial determination of whether the patient's needs can be met by hospice and if he/she meets eligibility criteria. (See Patient services policy: Admission Criteria and Process)

   B. All insurance coverage will be verified and documented. Commercial payor benefits will be reviewed for copay, deductible, maximum/minimum out of pocket costs, case manager requirements and other details.

   C. If the referral call is not from a physician, the patient's chosen attending physician will be verified and contacted to confirm service needs, as well as patient's medical prognosis and supporting documentation, and to obtain verbal orders to evaluate and possibly admit to hospice if eligibility criteria are met.

   D. The Clinical Director/designee will assign personnel and schedule an initial evaluation and/or assessment visit.

      FL State Specific: Response to the referral includes assigning personnel and scheduling and/or attempting to schedule the initial evaluation and/or assessment visit. Documentation of attempts to reach the patient/legal representative to schedule the visit will be documented to ensure compliance.

   E. If hospice services cannot be provided, Intake will notify the referral source, and provide names of other agencies that may be able to provide the required services and will notify the attending physician. The reason for non-admission and any planned follow up, along with documentation that the referral source and attending physician were notified, will be noted in the electronic health record.

6. After scheduled hours (weekends, evenings, holidays), referral sources will have access to hospice through the answering service and on-call procedures.

   A. The answering service will contact the on-call nurse

   B. The on-call nurse will complete the initial intake information from the referral source and document the information.

      Insurance verification and scheduling of the initial evaluation and/or assessment visit will occur as above.

INTAKE AND REFERRAL PROCESS	Policy Number:
CHAP Standard(s): HCPC 5.I	
Federal Regulatory Citation: 418.64	
State/Local Regulatory Citation: FAC 59A-38.004(3)(a)11	
Dates Reviewed/Revised: 3/1/2019; 4/30/202;	

SHALOM HOSPICE

INTERDISCIPLINARY GROUP COORDINATION OF CARE	Effective: 3/1/2019
Patient Services	Policy No.: 1032

PURPOSE

To ensure the coordination of services for each patient.

POLICY

The hospice interdisciplinary group will retain professional management responsibilities for the provision of services, including inpatient care, and will insure that services are furnished in a safe and effective manner.

Shalom Hospice will utilize a case management system to guide an interdisciplinary group to provide comprehensive, coordinated health care to patients and families/caregivers serviced by the hospice. It will be the responsibility of the Clinical Supervisor to assign a Case Manager who is a registered nurse. The Case Manager will be responsible for coordination of services with the interdisciplinary group from referral to discharge.

The type and scope of services provided by the interdisciplinary group will be based upon comprehensive and ongoing assessments regarding the needs of the patient and family/caregiver and the comprehensive plan of care that defines patient and family/caregiver problems, goals, and interventions. The exact combination of services and the level of care will be unique to each patient and family/caregiver unit and will change as the needs of the patient and family/caregiver evolve over the course of their involvement with hospice.

PROCEDURE

1. Each patient will be assigned a Registered Nurse Case Manager upon admission.
2. The RN Case Manager will be qualified through education, training, and/or experience and will:
    A. Understand the principles of care provided
    B. Know required qualifications for hospice personnel providing care and know which hospice personnel possess these qualifications
    C. Know the scope of care, which can be provided by various interdisciplinary group members
    D. Understand the nature of patient population served
3. It will be the responsibility of the RN Case Manager to facilitate communication about changes in the patient's status between interdisciplinary group members and the patient's attending physician.

4. Hospice personnel will communicate changes in a timely manner via telephone, one-to-one meetings, interdisciplinary group meetings, and home visits. Documentation of all communications will be included in the clinical record. Documentation will include the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication.

5. When the patient requires services from the interdisciplinary group, the RN Case Manager will be responsible for cooperative care planning to assure goals, interventions, and outcomes are palliative in nature.

6. Written evidence of care coordination will be found in the plan of care and/or inter-disciplinary team meeting forms in the patient's clinical record, and will involve the hospice patient's attending physician.

7. Care will be provided by an interdisciplinary group made up of physicians, nurses, social workers, hospice aides, homemakers, clergy, counselors, volunteers, and therapists. These services will be provided in both residence and inpatient settings.

8. The interdisciplinary group (in collaboration with the attending physician, if any) will conduct assessments, develop and update the plan of care, and review the effectiveness of care a minimum of every 15 calendar days. The attending physician will receive a copy of the care plan updates.

9. All interdisciplinary group members, including those providing contracted services, will have access to the plan of care to ensure coordination and continuity.

10. 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 at least twice a week; and participate in interdisciplinary group meetings. Care provided by contracted services will be monitored by the interdisciplinary group to insure compliance with the plan of care.

11. Continuity of care will be maintained throughout the patient's course with hospice. Exchange of information between hospice staff and contracted providers will be documented in the clinical record.

12. The interdisciplinary group will provide ongoing support for patient and family/caregivers.

13. Core hospice services (nursing, social work, physician, and counselors) will be available 24 hours a day, seven (7) days a week, as will be drugs, biologicals, and medical supplies. Other services may be available as needed and will include hospice aide, homemaker, therapies, and volunteer and bereavement services.

INTERDISCIPLINARY GROUP COORDINATION OF CARE	**Policy Number:**
CHAP Standard(s): HI.5c, HII.2b, HII.2c, HII.2d, HII.2e, HII.2f, HII.2i, HII.2j, HII.2k, HII.4b, HII.4c, HII.4d, HII.4f, HII.4g, HII.5, HII.5a, HII.5b, HII.5c, HI.2f, HI.2g, HI.2h, CII.4	
Federal Regulatory Citation: 42 CFR 418.56(a), (e)	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 3/1/2019	

SHALOM HOSPICE

INTERDICSIPLINARY GROUP MEETING	Effective: 3/1/2019
Patient Services	Policy No.: 1033

PURPOSE

To define the process for interdisciplinary group meetings and documenting patient status in the clinical record.

POLICY

The interdisciplinary group will meet on a regular basis to discuss patient and family/caregiver changes and progress and updates to the plan of care, deaths and changes in patient and family/caregiver circumstances, referrals, and admission/certification and recertification of patients on the hospice program. Each patient's plan of care will be updated utilizing the results from the ongoing comprehensive assessment no less frequently than every 15 days or more frequently if the patient's condition requires.

The meeting will be facilitated by the hospice Clinical Manager or designee. The hospice Medical Director or Physician and core hospice interdisciplinary group members will be present. Hospice Aides, Volunteers and Attending Physicians are welcome and encouraged to attend.

PROCEDURE

1. Members at the interdisciplinary group meeting will sign an attendance form that will be kept by the hospice Clinical Manager.
2. Referrals may be reviewed to establish appropriateness for hospice care. Obstacles to access of care issues will be identified and resolved.
3. Admissions will be reviewed to ensure eligibility using admission criteria and compliance with hospice policies and procedures.
4. Level of services will be reviewed for new and ongoing patients based on hospice team assessments. The group will approve recommendation for a change in the level of care.
5. The patient's plan of care will be updated no less frequently than every 15 days or more frequently if the patient's condition requires; social, cultural, and physical environments presenting obstacles to effective intervention; integration of alternative therapies into medical regime to assist in effectiveness; and any special needs of the patient.

6. A plan of care update will be completed for each patient and family/caregiver no less frequently than every 15 days utilizing the ongoing comprehensive assessment.

7. An interdisciplinary group meeting plan of care update form will be used for update of the patient and family/caregiver and the attending physician. It will note changes, response to treatment and progress toward targeted outcomes, which may include:

   A. Pharmacotherapeutic effectiveness of symptom management outcomes

   B. An increase or decrease in symptoms or acuity

      1. Nutritional status

      2. Pain management

      3. Condition of skin/presence/status of pressure ulcers

   C. Increases or decreases in frequency of visits by team members and reason for the change

      1. Missed visits by aides and staff will be explained and adjustment to the POC will be made if appropriate

   D. Changes in the location of care

   E. Psychosocial and other consultations/conferences with patient and family/caregiver

   F. Changes that may contribute to risk for pathological grief

   G. Ongoing spiritual support

   H. Plan for changes in treatments or procedures

7. Patient approaching recertification will be reviewed for the appropriateness of continuation of care based on identifiable criteria and progression of the terminal illness.

8. Patient requesting or requiring a transfer due to a change in the level of care necessary to meet his/her needs or a wish to utilize the services of another hospice will be reviewed and planning initiated for the transfer.

9. Patient being discharged from hospice will be reviewed to ensure appropriateness of ongoing care.

10. Problem solving for optimal care of the patient and family/caregiver will occur, and changes will be documented on the interdisciplinary group meeting form.

11. For patient residing in a skilled nursing facility, any changes in plan of care or patient education that has occurred during the visit will be communicated to the nursing staff of the skilled facility.

12. Grievances and issues of ethical concern will be discussed.

13. Patient requesting transfer to another hospice or revocation of the hospice benefit will be reviewed to determine any assistance he/she may need to complete these processes.

INTERDISCIPLINARY GROUP MEETING	Policy Number:
CHAP Standard(s): HII.4f, HII.4g, HI.2h	
Federal Regulatory Citation: 418.56, 418.62(b)	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 3/1/2019	

SHALOM HOSPICE

INTERDISCIPLINARY GROUP	Effective: 3/1/2019
Patient Services	Policy No.: 1034

PURPOSE

To define the membership and responsibilities of the interdisciplinary group.

POLICY

The interdisciplinary group will collaborate with the patient's attending physician, if one has been chosen, to develop an individualized written plan of care.

When there is more than one (1) interdisciplinary group, the hospice will designate in advance the group responsible for program oversight and the establishment of policies that govern the day-to-day provision of hospice care and services.

PROCEDURE

1. The hospice interdisciplinary group membership includes at a minimum:
   A. Hospice Physician
   B. Registered nurse
   C. Social worker
   D. Pastoral or other counselor (Position titles may be Spiritual Care Coordinator, Chaplain)
   E. **MA Specific**: Bereavement counselor and Volunteer coordinator
2. Additional members may include:
   A. Hospice aide
   B. Volunteer Manager
   C. Volunteer
   D. Pharmacist
   E. Registered dietician
   F. Physical therapist
   G. Occupational therapist

H. Speech therapist

I. Bereavement counselor

3. The interdisciplinary group responsibilities include but are not limited to:

A. Participation in the establishment of the plan of care for each patient admitted to the hospice program

NJ Specific

Initiated and implemented when the patient is admitted; coordinated and maintained by the interdisciplinary team; inclusive of, but not limited to, the patient's diagnosis, patient goals, means of achieving goals, and care and treatment to be provided; current and available to all personnel providing patient care and; included in the patient's medical/health record

B. Participation in the periodic review and updating of the plan of care for each patient receiving hospice services

C. Provision or supervision of hospice care and services

D. Establishment of policies and procedures governing the day-to-day provision of hospice care and services

E. Reviewing and resolving conflict of care and ethical issues

F. Provision of on-going support for and techniques to avoid overstepping boundaries

G. Planning for community education regarding hospice services

H. Participating in performance improvement activities

INTERDISCIPLINARY GROUP	Policy Number:
CHAP Standard(s): HI.5c, HI.2f, HI.2g, HI.2h, HII.2c, HII.2d, HII.2f, HII.2i, HII.2j, HII.2k, HII.4b, HII.4c, HII.4d, HII.4e, HII.5, HII.5a, HII.5b, HII.5c	
Federal Regulatory Citation: 42 CFR 418.56(a); 418.62(a), (b); also § 418.68	
State/Local Regulatory Citation: 105 CMR 141.203; 216-RICR-40-10-11.5.10	
Dates Reviewed/Revised: 3/1/2019	

SHALOM HOSPICE

NURSING SERVICES	Effective: 3/1/2019
Patient Services	Policy No.: 1042

PURPOSE

To specify the role of the nurse in hospice care.

POLICY

Nursing services will be provided in accordance with accepted standards of practice by or under the supervision of a registered nurse. Registered and licensed practical/vocational nurses will play a key role in easing physical and psychosocial symptoms and initiating communication with the interdisciplinary group to establish/update the plan of care.

RNs often delegate nursing tasks to other team members. A hospice registered nurse will be accountable for determining the level of supervision needed and for supervising those to whom any nursing task has been delegated. The registered nurse cannot delegate responsibilities related to making nursing judgments, for example, but not limited to, assessment and evaluation of progress toward goals or the outcome of interventions provided.

A hospice registered nurse will be assigned as the RN Case Manager for each patient and family/caregiver, and his/her duties will be enumerated in a job description. Duties will include the responsibility for coordination of care and fostering communication between the patient and the interdisciplinary group.

(See "Interdisciplinary Group Coordination of Care" Policy)

PROCEDURE

1. The hospice registered nurse performs the initial assessment and participates in the comprehensive assessment and ongoing updates of the comprehensive assessments to assess the impact of the terminal diagnosis on the patient's physical, functional, psychosocial and environmental needs and activities of daily living.

2. The hospice nurse will participate in developing and implementing the plan of care and will report the condition of patient and family/caregiver to the attending physician, Medical Director and interdisciplinary group on a regular basis, as well as changes in the plan of care.

3. The hospice nurse will:

   A. Manage discomfort and provide symptom relief.

B. Incorporate specialized nursing skills related to palliative and end-of-life care into all clinical care provided.

C. Provide patient and family/caregiver education regarding the disease process, self-care techniques, end-of-life care, and processes for addressing ethical issues.

D. Provide emotional support to the patient and family.

E. Assess for risks of pathological grief, cultural and spiritual implications and verbal and nonverbal communication patterns exacerbated by the terminal diagnosis.

F. Initiate appropriate preventive and rehabilitative nursing procedures.

G. Prepare clinical and progress notes that demonstrate progress toward established goals. **(NJ Specific)** A progress note will be written, signed and dated by the practitioner providing care within 48 hours of the provision of care, and the patient's response to the care be included in the progress note.

H. Coordinate all patient and family/caregiver services and prioritization of needs with the interdisciplinary group.

I. Use a case management approach and make referrals to other services as needed.

J. Provide specialized hospice training to other staff, family/caregivers to insure adequate care.

K. Provide an ongoing evaluation of the patient and family/caregiver response to care.

L. Assess the ability of the caregiver to meet the patient's immediate needs upon admission and throughout care.

M. Apply specific criteria for admission and recertification to hospice care to establish appropriate levels of care and the patient's eligibility.

N. Facilitate the implementation of another level of hospice care when necessary.

O. Assure communication between the hospice and other health care providers involved in the patient's care.

P. Participate in utilization review activities.

Q. Participate in quality assessment performance improvement teams and activities.

4. The hospice registered nurse will supervise licensed practical/vocational nurses, hospice aides, homemakers and volunteers in the home, and follow the family/caregiver into the bereavement period, per organizational policy.

5. A hospice nurse will be available on a 24-hour basis to meet the physical, psychosocial, spiritual, and practical needs of patients and families/caregivers admitted to the hospice program.

6. Direct provision of nursing care will be based on hospice nursing standards and clearly defined treatment protocols.

7. Patient and family/caregiver education and training activities will be initiated and continued throughout the course of care.

8. The hospice nurse will:

   A. Participate in inservice programs

   B. Evaluate his/her own needs for support and utilize available systems to meet these needs

9. **NJ Specific** Nursing Care shall also include the following:

   A. The promotion, maintenance, and restoration of health

   B. The prevention of infection, accident and injury

   C. The reassessment of the patient's nursing care needs on an ongoing, patient-specific basis and providing care which is consistent with the medical plan of treatment

   D. Nursing staff shall administer medications in accordance with all Federal and State laws and rules.

10. Licensed practical/vocational nurses will supplement the nursing care needs of the patient as provided by the registered nurse; this may include:

    A. Providing services in accordance with organizational policies and procedures

    B. Preparing clinical and progress notes documenting outcomes of interventions

    C. Assisting the registered nurse or physician in performing specialized duties related to end-of-life care

    D. Assisting the registered nurse in carrying out the plan of care

    E. Preparing equipment and materials for treatment adhering to aseptic technique as required

    F. Assisting the patient in learning appropriate self-care techniques

    G. Assessing patient and family/caregiver response to care

    H. Insuring communication of information to appropriate team members

NURSING SERVICES	**Policy Number:**
CHAP Standard(s): HCDT 6.1,	
Federal Regulatory Citation: 418.54, 418.56, 418.64, 418.76(g), (h), 418.100(c), (d), (g)	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 3/1/2019; 9/1/2019	

SHALOM HOSPICE

PATIENT FOCUSED PERFORMANCE IMPROVEMENT	Effective: 3/1/2019
QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT POLICIES	Policy No.: 3006

PURPOSE

To delineate the process for defining and measuring quality of services in terms of patient outcomes.

POLICY

The organization's performance improvement processes will focus on the quality of patient and program outcomes. In addition, the assessment, planning, implementation of care and services, and evaluation of goal attainment will be individualized to the specific patient.

PROCEDURE

Patient Specific Outcomes

1. At the time of admission and on an ongoing basis, an individualized plan of care/service including specific and measurable goals will be developed for each patient.

2. Focus will be on indicators related to improved palliative outcomes and time frames considered for goal attainment will be based on the patient and family's assessed abilities and circumstances

Organization-wide Outcomes

1. As part of the organization-wide performance improvement process, opportunities for improvement related to patient outcomes will be identified through continuous measurement of patient satisfaction survey results, clinical/service record review, monitoring of incidents and infection control reports and Adverse Event Outcomes Reports.

2. Program, or process related performance improvement activities will focus on opportunities to improve overall organizational performance.

3. When an opportunity to improve performance is identified, a focused study (indicator) will be developed to measure and improve associated processes and will be discussed in the next QAPI meeting. If indicated, it may be elevated to a performance improvement project.

4. Performance improvement projects are summarized and discussed in quarterly QAPI meetings and included in the meeting minutes for review by the Governing Body.

PATIENT FOCUSED PERFORMANCE IMPROVEMENT	Policy Number:
CHAP Standard(s): CII.6, I.5, HII.4, HII.10	
Federal Regulatory Citation: 418.58	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: **03/01/2019**	

SHALOM HOSPICE

PLAN OF CARE	Effective: 3/1/2019
	Policy No.:
Patient Services	1052

PURPOSE

To ensure that an individualized plan of care is completed for each patient that complies with regulations and accrediting body standards.

POLICY

A written, individualized patient and family/caregiver plan of care will be established and maintained for each patient admitted to the hospice program. The care provided to the patient must be in accordance with the plan of care. The plan of care will meet the documentation requirements of the physician-directed medical orders and the care planning process. The plan of care will be based on the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplinary group and will be reviewed on a regular basis but no less than every fifteen (15) days. This plan will focus on identified problems, goals, and interventions. The patient and family/caregiver will be encouraged to participate in the development of and continued updating of the plan of care. This plan of care must be initiated at start of care. (See Patient Services Policies: Initial Assessment, Comprehensive Assessment, and Ongoing Comprehensive Assessments)

PROCEDURE

1. The RN admission nurse or RN Case Manager completing the admission will complete the initial assessment and will initiate the development of the plan of care after the consent forms are signed. (See Patient Services Policy: Initial Assessment.)

2. The RN admission nurse or RN Case Manager will then notify the attending physician and a core member of the interdisciplinary group of the initial assessment findings, the identification of patient needs and the recommended services to meet those needs. The plan of care will be reviewed prior to care being delivered.

3. Orders for the start of care will be verbally received by the RN admission nurse or RN Case Manager completing the admission from the attending physician (or other authorized independent practitioner) and documented on the plan of care/physician order form.

4. The plan of care will identify the patient's needs and services to meet those needs, including the management of pain and discomfort and symptom relief. It must state, in detail, the scope and frequency of services needed to meet the patient's and family/caregiver's needs.

5. The individualized plan of care will be reviewed by the rest of the interdisciplinary group within two (2) days of start of care and ratified at the next IDG meeting.

6. The plan of care will be provided to both the attending physician, if the patient has chosen one, and the hospice Medical Director/physician for approval of verbal orders and certification of the terminal illness signatures. The hospice Medical Director/physician will need to review the patient's history and physical, which is also provided, to be able to sign the certification of terminal illness section of the plan of care.

7. Each patient will be monitored for his/her response to care or services provided against established patient goals and patient outcomes to evaluate progress toward goals.

8. Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing comprehensive assessments, and analysis of patient response to care against goals and outcomes.

9. The plan of care will be reviewed and revised as frequently as deemed necessary, but not less often than every 15 days, by the interdisciplinary group, with input from the attending physician (if there is one), the patient, and the family/caregiver, based on ongoing comprehensive assessments of the patient and family/caregiver. Review of the plan of care will be documented in the clinical record. Revision dates will be noted on the plan of care.

10. Any change in the patient's condition must result in a change in the plan of care, prior to implementation of the new service.

11. As needed, the patient and family/caregiver will receive written instructions regarding treatments or aspects of care that will be the responsibility of the patient and family/caregiver to provide or follow through with.

12. The written plan of care will contain, but will not be limited to, the following:

    A. Diagnosis and prognosis

    B. Resuscitation status or Advance Directives, POLST/MOLST or related education needs/requests as applicable

    C. Identification of patient and family/caregiver status, problems and needs, including physical, psychosocial, cognitive, cultural, spiritual, nutritional, functional, educational, grief and counseling.

    D. Reduction in risk factors

    E. Functional limitations

    F. Mental status

    G. Safety measures to protect against abuse, injury, infection, or communicable disease, as appropriate

    H. Nutritional requirements

I. DME and medical supplies necessary to meet patient needs

J. Frequency of services

K. Placement at the appropriate level of care (Routine, Respite, General In-patient, Continuous Home Care)

L. Referrals as needed for counseling, additional disciplines, volunteers, and adjunctive services

M. Individualized interventions to assist with end-of-life care, including use of available programs and services (i.e. Virtual Reality, Equine Therapy, Music Therapy, We Honor Veterans, Remote Care Program and other offered programs)

N. Patient and family/caregiver educational needs and assessment of their ability to learn and understand teaching and their ability to safely self-administer drugs and biologicals

O. Statement of treatment goals

P. Pain and symptom management interventions

Q. Drugs and treatments (including allergies)

R. Physician-directed instruction to patient and family/caregiver

S. Designation of the primary care giver or alternate plan to provide 24-hour care and support in the patient's home;

T. Emergency management plans for needed care and services, shelter and/or evacuation needs;

U. The designated RN Case Manager

V. Physician (or other authorized licensed independent practitioner) orders

W. Measurable outcomes anticipated from implementing and coordinating the plan of care.

X. Patient or representative's level of understanding, involvement and agreement with the plan of care

Y. Plans for support and care at the time of death;

Z. Plans for providing bereavement care to family, which may be located in a separate bereavement plan of care.

AA. Telehealth Services (Remote Care Program)

13. All appropriate hospice staff will have access to the plan of care.

14. Care provided to the patient will be in accordance with the plan of care

15. **WA State Specific**: Shalom Hospice will ensure that:

a. the plan of care is reviewed by the appropriate interdisciplinary team members within the first week of admission and every two weeks thereafter;.

b. the plan of care is signed or authenticated and dated by appropriate agency personnel and the authorizing practitioner;

c. the signed or authenticated plan of care is returned to the agency within sixty (60) days from the initial date of service;

d. the authorizing practitioner is informed regarding changes in the patient's condition that indicate a need to update the plan of care;

e. approval is obtained from the authorizing practitioner for additions and modifications; and

f. all verbal orders for modification to the plan of care are immediately documented in writing and signed or authenticated and dated by an agency individual authorized within the scope of practice to receive the order and signed or authenticated by the authorizing practitioner and returned to the agency within sixty(60) days from the date the verbal orders were received.

If providing a one-time visit for a patient, Shalom Hospice may provide the following written documentation in lieu of the hospice plan of care requirements for the state of Washington:

a. Patient's name, age, current address, and phone number;

b. Confirmation that the patient was provided a written bill of rights under WAC 246335-635;

c. Patient consent for services to be provided;

d. Authorizing practitioner orders; and

e. Documentation of services provided.

PLAN OF CARE	Policy Number:
CHAP Standard(s): HCPC 18.I, 21.I, 22.I	
Federal Regulatory Citation: CMS CoP: 42CFR418.52; 418.56; 418.76	
State/Local Regulatory Citation: MA Dept. of Public Health 105CMR §141.201; WAC 246-335-640; 400.6095(5) FS	
Dates Reviewed/Revised: 3/1/2019; 9/1/2019; 3/17/2020	

SHALOM HOSPICE

SCOPE OF SERVICES	Effective: 3/1/2019
Patient Services	Policy No.: 1059

PURPOSE

To describe Shalom Hospice operations including business office hours and geographical service area.

POLICY

Shalom Hospice provides hospice services that palliative in nature and are intended to meet the physical, psychosocial, practical, and spiritual needs of hospice patients and their families/caregivers.

Shalom Hospice will operate an office that will provide a safe and adequate location related to space, facilities, and administrative services. Regular business hours will be maintained Monday through Friday, except designated holidays or other days decided by the Executive Director/Administrator.

Drugs, biologicals, and core hospice services provided by nurses, social workers, physicians, and bereavement counselors are available 24 hours a day, seven (7) days a week. Other covered services are available on a 24-hour basis to the extent necessary to meet the patient's needs relating to palliation and treatment of the terminal illness and/or treatment of related conditions.

PROCEDURE

1. Shalom Hospice will define its' service area, post its' regular business hours and inform patients and their caregivers/families how to reach personnel after hours. (See Geographic Service Area Form)

2. Hospice services will be provided to terminally ill patients in their place of residence, which could be in the patient's own private residence, a skilled nursing facility, assisted living, or other living arrangements.

2. An interdisciplinary group of professionals and volunteers will develop with each patient and family/caregiver a plan of care, which will include, as appropriate, the following services:

   A. Physician

   B. Registered nurse

   C. Medical social worker

   D. Counseling services

E. Spiritual support
F. Therapists (physical, occupational, and speech)
G. Dietary counseling
H. Hospice aide
I. Homemaker services
J. Hospice volunteers
K. Consultant pharmacist
L. Durable medical equipment related to the hospice patient's terminal diagnosis
M. Medications and medical supplies related to the hospice patient's terminal diagnosis
N. Inpatient care: short-term stay for symptom control and planned respite for family/caregiver
O. Bereavement follow-up for at least one (1) year after death

4. Routine home visits will be provided according to the plan of care including scope and frequency.

5. Continuous care will be provided for up to 24 hours per day during periods of crisis and may include nursing, hospice aide, social worker, or personal care of volunteer services. A minimum of eight (8) hours during a 24-hour period will be available during crisis. More than one-half of the total hours of care provided during each 24-hour period must be provided by a skilled nurse.

6. Inpatient respite care will be provided only in a Medicare/Medicaid facility, on a short-term basis to assist the family in their ability to provide continuing care to the patient.

7. General inpatient care will be arranged when the patient requires care for pain control and/or symptom management.

8. Transportation services required by the patient in the provision of hospice care will be coordinated by the organization.

SCOPE OF SERVICES	**Policy Number:**
CHAP Standard(s): HI.5d, HII.1b, HII.2, HII.2a, HII.2b, HII.3 418.56(c)	
Federal Regulatory Citation: 418.64, 418.70, 418.72, 418.100(a), (c), (f), (g), 418.106, 418.108	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 2/28/2019	

SHALOM HOSPICE

SPIRITUAL ASSESSMENT	Effective: 3/1/2019
Patient Services	Policy No.: 1061

PURPOSE

To provide guidance for the assessment and reassessment of the spiritual needs of patients and families/caregivers.

POLICY

A spiritual assessment will be completed for each patient/family by the Chaplain. The assessment will include, but not be limited to, evaluation of the following:

1. Coping with and adjusting to the patient's terminal illness
2. Assessing bereavement needs
3. Religious and/or spiritual reactions to terminal illness (See "Spiritual Care Counseling Services" Policy)

PROCEDURE

1. On admission, the hospice registered nurse will conduct an initial spiritual assessment.
2. The Chaplain will contact the patient/family by a home visit or by telephone based on the patient's and family's needs and acceptance of these services.
3. If the patient and/or family/caregiver refuse these services, the refusal will be documented. The interdisciplinary group members will continue to assess for spiritual needs and offer appropriate services to the patient and/or family/caregiver.
4. The in-depth spiritual assessment will be performed by the Chaplain:
    A. In the patient's residence
    B. In the hospital if the patient is hospitalized at the time of intake
5. The spiritual assessment will include, but not be limited to:
    A. Patient's spiritual response to the terminal illness and treatment interventions
    B. Survivor risk factors, such as availability of coping mechanisms and the potential for pathological grief reactions

C. Available religious spiritual support

D. Coping styles and impact of illness on spirituality

E. Anticipatory grief assessment

6. The assessment will be completed and placed in the patient's clinical record.

7. After the spiritual assessment is performed, ongoing contact will be maintained by phone and/or home visits by the Chaplain if requested by the patient and family/caregiver and will be included in the comprehensive assessment and the plan of care.

SPIRITUAL ASSESSMENT	Policy Number:
CHAP Standard(s): HII.2e12	
Federal Regulatory Citation: 418.64 (d3)	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 03/01/2019	

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Jewish Ritual, Reality and Response at End of Life

Jewish Ritual, Reality and Response at the End of Life

A Guide to Caring for Jewish Patients and Their Families

Prepared by Rabbi Mark A. Popovsky
For the Duke Institute on Care at the End of Life
May 2007

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About the Author

Rabbi Mark A. Popovsky graduated from Columbia University and was ordained at the Jewish Theological Seminary, where he also received a Master's Degree in Talmud and Rabbinics. He currently serves as the Coordinator of Jewish Chaplaincy at New York Presbyterian Hospital in Manhattan. He teaches medical students at the Weill Cornell Medical College and has published several articles addressing emerging topics in the fields of pastoral care and medical ethics.

About the Institute

The Duke Institute on Care at the End of Life, based at Duke Divinity School, works to improve the care of seriously ill patients and their families by creating knowledge and rediscovering old wisdoms about the spiritual dimension of end-of-life care. For more information about ICEOL, visit us online at www.iceol.duke.edu.

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DUKE INSTITUTE ON CARE AT THE END OF LIFE

Dear Reader,

Thank you for your interest in *Jewish Ritual, Reality and Response at the End of Life: A Guide to Caring for Jewish Patients and Their Families*. It is our hope that you find it a valuable resource for patient care, as well as an interesting exploration of Judaism's rich traditions.

Judaism provides a vision for compassionate care throughout the continuum of illness—from sickness and death to grieving and mourning. The traditions span centuries, and the rituals remain relevant in contemporary society. The practices have meaning for those immersed in Jewish faith and culture and provide lessons for others. In this way, the value of this guide extends beyond better care for Jewish patients and families to better care for all who face life's end.

The Duke Institute on Care at the End of Life works to improve care by creating knowledge about the intersection of spirituality and health care at the end of life. This guide exemplifies that work by providing insight into Jewish approaches to life's end and highlighting the implications for caregiving. This book was developed as a companion to our 2007 conference of the same name.

The Institute thanks the dedicated committee who brought their thoughts, knowledge and expertise to bear on this guide. Committee members included Linda Belans, Director, Health Arts Network at Duke (HAND), Rabbi Michael Goldman, Jewish Life at Duke, Dr. James Tulsky, Professor of Medicine and Director, Duke Center for Palliative Care and Erica Rothman, independent consultant.

The Institute and the committee are indebted to the author of this guide, Rabbi Mark A. Popovsky, for his enthusiasm for this project and his expertise. We are grateful for his ability to put words to the vision of the committee. Joseph Matthews also deserves thanks for his thoughtful editing.

The Institute is a dynamic resource for those interested in spiritual perspectives of advanced illness, death and grief. We invite you to learn more about us, our work and other educational offerings at www.iceol.duke.edu.

Sincerely,

Richard Payne, M.D.
Professor of Divinity and Medicine
and Esther Colliflower Director

Jeanne Twohig, M.P.A.
Deputy Director

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The *Kaddish*

(a translation from the Hebrew)

Magnified and sanctified
is God's great name throughout the world
which God created.
Speedily may God's kingship reign
for all our days, during our lifetime and
the lifetimes of all the people of Israel.
Let us say: Amen.

May God's great name be blessed
throughout eternity.

Blessed, honored, glorified, exalted,
extolled, decorated, lauded and praised
is God's holy name beyond all blessing,
song and tribute that we may ever offer.
Let us say: Amen.

May great peace descend from the
heavens along with full life upon us and
upon all Israel. Let us say: Amen.

May the One who makes peace in the
universe grant peace to us and to all
Israel. Let us say: Amen.

I. Introduction

This is a guide for healthcare professionals, chaplains, social workers, funeral directors, family caregivers and others caring for Jewish patients and their families through illness, death and bereavement. Its mission is to introduce the reader to core Jewish concepts surrounding end-of-life care and to provide practical suggestions for responding to sometimes complicated situations in which the clinical, religious and cultural are entwined. The guide introduces the reader to Jewish beliefs and practices regarding illness, death and loss.

One of the greatest challenges for some non-Jewish caregivers working with Jewish patients and families is coming to understand Judaism as both a religion and an ethnicity. The fact that a patient has a Hebrew name or wears a Star of David may indicate that a patient is Jewish, but these markers alone do not predict how that patient self-defines and acts on his or her Jewishness. For example, a Jew may altogether reject Jewish faith or be utterly nonobservant of religious rituals yet firmly remain a Jew in his or her own self-definition, strongly identifying with Jewish historical and cultural traditions. However, even this category can be a fluid one, with some non-religious Jews returning to certain formal religious rituals as death approaches.

Throughout the guide, attention is paid to this complicating aspect of Judaism, which can present difficulties for caregivers—that is, that there is no uniform way of "being Jewish," no single Jewish approach to any given situation. The task of this guide is to teach about the beliefs and customs regarding illness and death that many Jews share, while simultaneously preparing caregivers for the fact that many other Jews may adapt, ignore or altogether reject these same principles and practices.

Because of the wide variety of American Jewish beliefs and practices, this guide refrains from generalizing about how clinicians and other caregivers should treat Jews as a group. Rather, the intent is to introduce basic concepts and common themes so that, in any individual case, a caregiver can find guidance about questions to ask and resources to call upon. Toward this end, the guide makes extensive use of personal narrative. Often these stories are exemplars of basic topics; at other times, they provide counter-examples to the traditional or mainstream Jewish approaches discussed. In all cases, names and other identifying data have been changed to protect anonymity.

Each subsection of this guide stands on its own so that the reader may quickly find information about a specific topic. Additional resources for clinicians, caregivers, patients and families are suggested within most sections. A directory of commonly used terms immediately follows this introduction. All Hebrew and Yiddish terms are translated and defined where they first appear in the text; for quick reference, they are also listed and defined again in the glossary at the end of the guide.

A Wide Spectrum of American Jewish Belief and Practice

As with most religions, Jewish beliefs and practices vary among Jews of different backgrounds, different levels of spiritual engagement and different organizational affiliations. The spectrum is even more complicated because Judaism also encompasses a culture and history that is ethnic as well as religious. This means that for many people their Jewishness derives not so much from a continuously observed set of formal religious beliefs as from family and regional histories—which, overwhelmingly in North America, originate among Central and Eastern European Jews, referred to as Ashkenazi Jews.

The following continuum among contemporary American Jews attempts to sketch some of these complexities. The lines between the categories are blurred and often crossed. Nonetheless, they can give caregivers a sense of the range of beliefs and practices they may encounter in their Jewish patients and their families.

Secular Jews—Approximately one-half of American Jews do not formally affiliate with any religious institution. These Jews may base their Jewish identity on family tradition and on the history of the Jews as a culture and an ethnicity—a "people." They might not hold any religious faith at all, or perhaps have some sense of religious belief without observing religious rituals, attending religious services at the synagogue, or adhering to religious restrictions. Nonetheless, they may feel strongly about being Jews and follow some Jewish practices handed down to them within their families. When faced with the end of life, they may seek comfort in certain religious rituals.

Religious Jews—Religious Jews follow the particular Jewish rituals and practices as interpreted by the specific movement of American Jewry—Conservative, Reconstructionist, Reform or Orthodox—to which they belong. Those who belong to the Reform and Reconstructionist movements generally exhibit the greatest flexibility regarding ritual and practice; those in the Conservative and Orthodox movements may adhere more strictly to traditional rules of conduct, especially with respect to ritual matters. Religious Jews who give great weight to traditional practice in their daily lives are often referred to as "observant Jews."

Orthodox Jews—Orthodox Jews generally adhere most strictly to formal ritual practice. Nevertheless, among different Orthodox and ultra-Orthodox communities, there are significant variations in practice.

II. Commonly Used Terms

The following are terms that appear throughout this guide.

Judaism—The common religion of the Jewish people, evolved from the religion of the ancient Israelites and modified through millennia of rabbinic interpretation and folk practices.

Jewish tradition—The corpus of Jewish teachings, beliefs and practices. It includes Jewish law, narratives, biblical exegesis, homiletics, folk wisdom and literature.

Traditional Jews—Used here interchangeably with "Observant Jews," this term describes Jews whose daily lives are influenced heavily by Jewish law and traditional Jewish practices.

Jewish law—Attempts to translate biblical teachings, as interpreted by rabbis, into contemporary practice. Jewish law encompasses all aspects of individual and communal life. It is characterized by an extremely high tolerance for debate and dissenting opinions.

Torah—In its most narrow sense, describes the first five books of the Hebrew Bible—Genesis, Exodus, Leviticus, Numbers and Deuteronomy. Many people, however, use the term more broadly to describe all aspects of Jewish law.

Talmud—A vast, almost encyclopedic, text containing rabbinic law, narrative, biblical exegesis, folk wisdom and ethical guidance, compiled in ancient Babylonia. Together with the Torah, it is the basis for much of contemporary Jewish law and practice.

Rabbi—From the Hebrew word for "great," Rabbi is the title bestowed on Jewish religious leaders with formal training. Some rabbis may lead congregations, others may works as teachers, chaplains or professionals in other capacities. Some Jews look to their rabbi for general spiritual and ethical guidance. Others may seek specific counsel and even permission from their rabbi prior to making major life decisions, especially regarding end-of-life care. Unless directed otherwise, a rabbi should be addressed "Rabbi [last name]."

Hebrew—Ancient Hebrew is the language spoken by ancient Israelites and in which most of the Hebrew Bible and many Jewish religious texts are written. Modern Hebrew is the primary language among Jews living in the State of Israel. Clinicians are most likely to encounter Hebrew when hearing reference by a patient or family to a Jewish ritual practice or belief, as well as when treating patients from Israel.

Yiddish—Was the primary language of Eastern European Jewry until the Holocaust. It derives from medieval German and imports many words and phrases from Hebrew as well as some from Slavic languages. It is written with Hebrew characters. Yiddish is today the primary spoken language for only small pockets of Jews in North America and Israel; however, its pronunciation, phrases and expressions heavily influence the speech of many Jews today.

Clinicians are most likely to encounter Hebrew when hearing reference by a patient or family to a Jewish ritual practice or belief, as well as when treating patients from Israel.

Sabbath—A day of rest, prayer and family life extending from Friday sundown through Saturday sundown. For those who observe Jewish law, working, writing, traveling, the use of electricity, the spending of money and many other activities are forbidden on the Sabbath. It also mandates communal prayer, festive meals and study.

III. Providing Care During Illness

Judaism includes particular traditions concerning family and community engagement with the ill. It also offers ritual responses to illness that may provide comfort to the patient and family. This chapter explores the particular ways in which Jewish tradition understands and responds to suffering, pain, illness and aging. It describes common beliefs and practices, and suggests approaches for effective care. All of the discussion is informed by the notion within Jewish tradition that *refuat ha-nefesh* and *refuat ha-guf*—healing of the soul and healing of the body—are profoundly interrelated.

Jewish Attitudes toward Suffering and Caring

The following passage from the Talmud offers an exemplar of the traditional Jewish attitude toward suffering, neither ignoring nor romanticizing it.

> Rabbi Eleazar grew sick, so Rabbi Yoḥanan went to visit him. Rabbi Yoḥanan saw that Rabbi Eleazar was weeping and said to him, "Why do you weep? Is it because you did not study enough Torah? Certainly you learned: The one who studies much and the one who studies little share the same merit, as long as their hearts are directed to heaven. Is it perhaps because you lacked wealth? Not everyone may enjoy two tables. Is it perhaps because you lacked children? This is the bone of my tenth son!"
>
> Rabbi Eleazar replied to him, "I weep because of my beauty that is going to rot in the earth."
>
> Rabbi Yoḥanan said to him, "For that, you surely have reason to weep." They both cried together.
>
> Rabbi Yoḥanan further said to him, "Is your suffering welcome to you?"
>
> Rabbi Eleazar replied, "Neither it nor its reward."
>
> Rabbi Yoḥanan said to him, "Give me your hand." So he gave him his hand and he raised him up.
>
> — The Talmud

This Talmudic passage also presents the paradigmatic model of good Jewish care for the sick. In the story, Rabbi Yoḥanan first attempts to understand what is causing his colleague to suffer, recognizing that each individual's experience is different. Through the discussion, he directs the ill rabbi away from focusing on vain regrets towards confronting the present reality in which many of life's blessings are lost. He validates rather than denies Rabbi Eleazar's suffering. The story also employs humor—not to mask the pain of the situation but to affirm that life continues and can be appreciated even at its end.

The story also includes Rabbi Eleazar's rejection of the suggestion that suffering is to be desired or may be given by God for his benefit. The Talmud teaches that God sits at the head of a sick person's bed, a partner and companion through illness, not a punisher. Though Jewish tradition has always searched for ways to find opportunities for growth, regeneration and spiritual development in suffering, few voices in Judaism argue that suffering is good. Judaism permits the sufferer to reject greater meaning in suffering; suffering need not be viewed as a sign of courage or a mark of pride for the Jewish patient but rather something simply to be avoided.

Rabbi Yoḥanan concludes the visit by reaching out physically, a gentle act offering temporary respite from pain. The suffering is mitigated as both the physical and spiritual pain are addressed simultaneously. This model of holistic care informs the following discussion of Jewish responses to illness.

Care through Visiting the Sick—*Bikkur Ḥolim*

The Hebrew phrase *bikkur ḥolim* literally translates as "visiting the sick." However, it describes a much broader concept in Judaism which obligates healthy family, friends, acquaintances and other community members to provide a range of care for all who are sick. The tradition makes no distinction between addressing the patient's physical and emotional needs. The primary task of the *bikkur ḥolim* visitor is to help patients maintain their dignity despite the challenges of illness. This is usually best accomplished through the visitor's attention to detail. The Talmud offers the example of sweeping the floor in the room where the person lies; in modern terms, this might mean such acts as delivering warm food or coffee, bringing books or music which the patient enjoys, or helping the patient to decorate a hospital room with cards and pictures so that it feels more personal. Sometimes a *bikkur ḥolim* visit may be as little as arriving and letting the patient ask the visitor to leave. A hospital patient has little say over who enters the room or when. The visitor restores dignity to the patient by honoring

For contemporary perspectives on the meaning of suffering and illness in Jewish tradition, see *When Bad Things Happen to Good People*, Harold Kushner, Anchor, 2004, and *Jewish Paths Towards Healing and Wholeness: A Personal Guide to Dealing with Suffering*, Kerry Olitzky, Jewish Lights Publishing, 2000.

his or her request to return at another time.

The community's obligation to provide care extends to all those affected by illness. Often, close family members fail to adequately care for themselves as they provide care to a sick loved one. So, someone performing *bikkur ḥolim* may offer to help baby-sit, run errands, establish a phone tree to pass on information, or otherwise help to reduce the burden on the family. Sometimes a *bikkur ḥolim* caregiver will simply sit in the patient's room while a family member reluctant to leave the patient alone returns home for a few hours to shower and change clothes.

> What is the difference between one who is sick and one who is considered dangerously ill? One who is merely sick is so in the normal way. "Dangerously ill" refers to one whose sickness came suddenly. For a normal sickness, relatives visit immediately and those more distant visit after three days. But if the sickness came suddenly, both relatives and those more distant can visit immediately. Rabbi Huna, Rabbi Pinḥas and Rabbi Hikah desisted from visiting Rabbi Yossi for three days. Rabbi Yossi said to them, "Through me you must fulfill this teaching?!"
>
> THE TALMUD

The Talmud reports that Rav Huna once taught that visiting the sick removes one-sixtieth of a person's illness. Rav Huna's students immediately objected, noting that if a person had sixty visitors, then his illness should be cured. Rav Huna agreed, but only when all sixty visitors "love the sick person as they love themselves." While this teaching sets a high standard for caregivers, it stresses the need for empathy. Rarely do health care professionals talk with a patient while sitting at the bedside on the same level as the patient, sustaining eye contact. In contrast, formal Jewish laws of *bikkur ḥolim* require the visitor to sit at eye level with sick person. The concept of *bikkur ḥolim* bids caregivers, professional and otherwise, to reject false hierarchies whenever possible, and to meet the sick person at his or her level, accompanying the patient through the challenge of illness.

A respectful *bikkur ḥolim* visitor lets the patient guide the course of a visit. The visitor should be sensitive to clues that the patient provides about the scope and subject of conversation, and not project his or her own agenda onto the patient. Some patients find it easier to discuss certain aspects of their emotional experience with people outside of their close family and friends. Others may desire a break from discussing their illness but wish to hear news about the synagogue community or details about what is happening at work. Immobility due to illness often prevents people from finding adequate intellectual stimulation; thus, some patients may want to discuss current events or culture in order to feel connected to these worlds and to remain mentally sharp.

At the same time, many people would like to discuss their illness and its emotional toll. They refrain only because they fear the visitor may not be able to cope with such matters. Each *bikkur ḥolim* visit should include at least a few gentle invitations for the sick person to speak about what is most difficult, including the emotional and spiritual impact of illness. To this end, author and professor Rabbi William Cutter encourages *bikkur ḥolim* visitors to ask, "How is this experience affecting your belief in God?" If the visitor's invitations to begin this or a similarly intense conversation are declined, the visitor should respect the patient's wishes.

Most synagogues and some other Jewish organizations have a *bikkur ḥolim* committee of volunteers who provide support to sick people and their families. Many of these organizations will deliver fresh-cooked kosher food, send visitors and continue to provide support following discharge. They can also refer the sick person to an appropriate rabbi or pastoral counselor when indicated. Whereas once these groups were provided lists of all the Jewish patients in a facility, health privacy standards established by the Health Insurance Portability and Accountability Act (HIPAA) now prohibit a facility from initiating contact. Clinicians can familiarize themselves with local *bikkur ḥolim* resources by consulting institutional chaplains or local synagogues; they may then inform a patient or family in need about the existence of the resource and provide contact information.

For a detailed treatment of *bikkur ḥolim* from an Orthodox perspective, see Joseph Ozarowski, *To Walk In God's Ways: Pastoral Perspectives On Illness and Bereavement*, Jason Aronson Publishing, 1995.

The Chai Lifeline (www.chailifeline.org) is an international *bikkur ḥolim* organization providing support to sick Jewish children and their families.

Caring for Someone Who Cannot Respond

When a patient is in a coma, in a state of advanced dementia, heavily sedated or otherwise unable to speak, visitors and caregivers can feel lost: What do I say? What do I do? Does it even matter if I visit? The great contemporary Jewish legal scholar Rabbi Eliezer Waldenberg opines that a Jew fulfills his or her obligation to visit the sick even when no words are spoken or when the patient is not conscious. This builds on a core understanding of Jewish tradition that profound and intimate communication can take place even without a single word being uttered.

Especially when one remembers a person full of life and fluid in speech, it can be very painful for a family member, friend or even a seasoned professional to enter a patient's room when basic language is no longer possible. Jewish tradition encourages people to overcome this natural discomfort and not abandon the patient to loneliness and isolation. Many believe that music and prayer are able to penetrate deep into the mind even when standard verbal communication is impossible. If uncomfortable with song and prayer, the visitor may want simply to sit at the bedside in silence and hold the patient's hand. One of the most caring acts a person can do is to use a lollipop-like sponge or chips of ice to wet the patient's dry and cracked lips. The specifics do not matter. What is important, according to Jewish tradition, is that the visitor remains present.

> Heal us O Lord and we shall be healed, save us and we shall be saved; for You are our praise. Grant a complete healing for all our wounds; for You are God, the King, the faithful and compassionate Healer. Blessed are You, O Lord, who heals the sick of His people Israel.
>
> TRADITIONAL PRAYER FOR HEALING

Prayer as a Response to Illness

The seminal code of Jewish law declares that in order to fulfill the obligation to perform *bikkur ḥolim*, a visit to the sick should include an offer of prayer. Prayer can empower those who feel helpless. The prayer need not be recited in Hebrew from a fixed liturgy—there is a strong tradition in Judaism of informal and spontaneous prayer. Jewish prayer may take the form of a request or an expression of gratitude—anything that can help the individual articulate what is most important, or to appreciate the blessings in one's life, when despair takes hold. Jewish prayer also commonly takes the form of a complaint or expression of anger.

Many Jews today, even some with a religious orientation, feel alienated from prayer. For Jews wishing to pray but unable to formulate their own prayers, the tradition provides many models of prayers for various occasions. A rabbi or chaplain can help a patient or family member find an appropriate prayer for times of fear, depression, anxiety, recovery, transition and confusion. When a patient or visitor is uncertain about how to pray, a common beginning point is to read selections from the biblical book of Psalms—known as *Tehillim* in Hebrew. Someone, Jew or non-Jew alike, wishing to offer a blessing to a Jewish person in need can always use the words of Numbers 6:24–26:

> May God bless you and protect you.
>
> May God deal kindly and graciously with you.
>
> May God lift up his countenance towards you and grant you peace.

Prayer for the ill may also be performed at the synagogue. During worship services when the Torah is read publicly, the rabbi or prayer leader may chant a prayer for communal healing called a *mi-sh'berakh*. This prayer offers a space for the names of specific individuals to be recited aloud so that the entire community may pray on their behalf. Most synagogues keep ongoing lists of members in need of healing which are read aloud, followed by time for attendees to state other names. A *mi-sh'berakh* prayer requests that both *refuat ha-nefesh* and *refuat ha-guf*—healing of the soul and of the body—come speedily to all in need. When known, the person's Hebrew name is used. Though Jews are traditionally called for ritual purposes by the father's name, in times of illness, those in need are called by their mother's name—an effort to evoke images of comfort and nurture.

Rituals Performed During Illness

Prayer is not the only ritual response to illness. Traditional Jews may perform a ritual called *pidyon ha-nefesh*—redeeming the soul. As part of this ritual, a group of elders offers prayer, studies Torah and collects money for charity on the sick person's behalf. Some Jews of Arab or Persian descent may

For a collection of traditional and modern Jewish prayers, see *Gates of Healing*, CCAR Press, 1988.

For modern rituals and readings during times of illness, see www.ritualwell.org (click on "Lifecycles," then "Healing and Hard Times").

also slaughter a chicken on behalf of the one who is ill, using the meat to feed the hungry. The goal is to spiritually cleanse the person's soul through good deeds and, in so doing, appeal to God's mercy.

> Living with pain can be even worse than death.
>
> COMMENTARY OF THE *TOSAFOT* TO THE TALMUD

During times of serious illness, many Jews follow the custom of changing their given name or adding an additional name. This may have originated as an effort to confuse the angel of death. However, many modern Jews continue to find meaning in this practice as it affords hope and serves as a reminder that major transformation is always possible, even in the darkest hour. The new name selected usually relates to long life or good health. Common new names for men include Chaim (life), Alter (long life) or Raphael (God will heal). Women often select Chaya (life) or the names of biblical matriarchs who lived well into their old age such as Sarah.

Pain Management

Jewish law has always required the aggressive treatment of pain to the same degree that it requires the treatment of disease. As pain restricts people's ability to perform the acts and carry out the routines by which they define themselves, they stop feeling like themselves. The Talmud explains, "The rabbis did not seek to enforce their decrees in cases of pain." Because they wanted devotees to return to normative religious observance as quickly as possible, the rabbis of the Talmud placed great emphasis on pain management.

Despite this longstanding traditional attention to pain alleviation, certain aspects of Jewish culture may prevent some Jews from receiving aggressive pain care. The Jewish people have suffered terrible tragedies throughout history. In response, some Jews have internalized the implicit message that pain is to be expected as a natural and necessary part of the human condition. Left unexplored, such a belief can weaken an individual's resolve to treat pain.

Communicating with Patients and Families

The issue of clinician–patient communication can be complicated by a potential conflict between the modern medical community's emphasis on full disclosure and a residual Jewish tradition of sometimes withholding devastating information. Traditional Jewish resistance to full disclosure in some medical situations stems from Judaism's sensitivity to the patient's mental anguish and emotional suffering. Ancient Jewish sages understood that the insensitively abrupt disclosure of bad news could trigger panic, anxiety or depression, weakening that person's emotional and spiritual resources to cope. Many rabbis have argued for withholding critical information about a patient's prognosis in order to help him or her maintain confidence in recovery. Because Jewish sages understood

Special Issues in Caring for Holocaust Survivors

A RABBI'S EXPERIENCE:

> I was called by a patient's daughter to help her 89-year-old hospitalized father to put on *tefillin*, the black boxes containing biblical verses which observant Jews strap to their arm and head during daily prayers. As we began, I noticed that the patient had a bandaged but still open wound on his left bicep where he usually attached his *tefillin*. I suggested that he attach them to his right arm instead this morning so as not to further irritate the wound. The heretofore sweet man aggressively insisted that I continue laying the *tefillin* on his left arm. I gently reminded him that the *tefillin* contain biblical passages and that one should be very careful to protect them from contact with bodily fluids. At this point he lifted his left arm, showed me the serial number tattooed into it by the Nazis, and exclaimed, "The *tefillin* must cover this up while I pray!"

Many Holocaust survivors do not discuss their experiences openly or frequently, but caregivers must be sensitive that the trauma of the Nazi extermination efforts necessarily colors every major life experience afterwards, especially the challenges of illness, loss and death. The trauma affects not only those with tattoos who personally survived concentration camps, but any Jew in Europe before the war who faced forced deportation, displacement, the severing of families and the loss of loved ones.

While there are as many different narratives as there are survivors, common themes in many survivors' stories include feelings of extreme isolation, fear, shame and betrayal. No one should expect that a survivor's experiences in the Holocaust—or *Shoah*, as many Jews today refer to it—are so distant as to no longer significantly affect his or her perception of the world. Some survivors distrust institutions, consistently reject help from others and occasionally direct rage towards unsuspecting targets. Others, however, may forge intense bonds with friends and caregivers, having reached a profound spiritual connection through the process of overcoming their life's challenges.

The Jewish community has made great efforts in the past decades to struggle against the shame that many survivors feel and to encourage survivors to tell their stories. Many survivors who are now ill will be comfortable speaking about their experiences. Others may still carry the burden of great shame and guard their stories closely. Still others who have yet to tell their stories may wish to take this last opportunity to share their experiences before death. When working with patients who are survivors, one should be careful never to exert pressure to speak about the Holocaust experience. At the same time, the healing professional should provide opportunities for survivors to share their stories. Helping those who have lived through the *Shoah* to explore and articulate the internal resources that allowed them to survive and even overcome the trauma can be an important step in uncovering the resources they may now have to face the challenges of aging, illness and death.

the profound connection between hope and healing, they insisted that all efforts to sustain hope be pursued, even at the price of honesty.

In a time when a patient's ability to autonomously decide among treatment options was irrelevant because no treatment options existed, this line of reasoning had greater justification. In the modern era, however, where full disclosure is necessary for a patient to participate adequately in his or her own care, many rabbis agree that the rationale to withhold the truth no longer stands. Jewish tradition places great emphasis on the proven effectiveness of an intervention. Because there is no evidence today that withholding a terminal diagnosis or other bad news provides patients with a survival advantage or increased function, the argument to refrain from truth-telling is greatly diminished. The counter-evidence that a patient's active participation in his or her own treatment can actually improve outcomes demands that rabbinic authorities reconsider their discomfort with the direct disclosure of relevant medical information. However, ancient values shift only slowly and some rabbis and Jewish families have not accepted the above arguments.

There is yet another reason that clinicians need to tread carefully on the question of full disclosure to some Jewish patients. One of the primary reasons to speak honestly with a patient about his or her condition is to respect that person's individuality and autonomy. Jewish tradition, however, rejects any narrow definition of individual autonomy and holds that, if a patient does not wish to know about his or her prognosis, respecting that patient's autonomy requires withholding the truth. For this reason, whenever possible, clinicians should attempt to assess in advance what information a patient does or does not want disclosed. Documenting and later respecting these wishes represents a much more profound affirmation of the patient's autonomy than a blanket assumption that full-disclosure is always preferable.

As a result of the lingering Jewish tradition of non-disclosure and of some patients' individual preferences, Jewish family members may resist a physician's wish to speak frankly with a patient about his or her condition. This can lead to an antagonistic dynamic between the family and the medical staff. Involving chaplains and social workers to help the family process their own anxiety about illness may reduce tensions. Clinicians may also invite religious Jewish patients to include their rabbi in sensitive discussions. When it is determined that full disclosure is appropriate, the Jewish model of physician communication is careful to distinguish truth-telling with information dumping, which may disable a patient or family with the weight of excessive medical facts and jargon.

Gender Issues with Orthodox Patients

Many Orthodox Jews today observe strict rules governing social interactions between men and women. Not every Orthodox patient observes all of these rules, and within the healthcare setting many Orthodox rabbis permit significant leniencies. Clinicians should be aware that a patient accustomed to observing these practices may feel especially anxious or vulnerable when the procedures of an institution force the patient to temporarily suspend them. If health care professionals communicate appropriate empathy for the patient's situation and help the patient to observe these practices—even if only in modified form—the therapeutic relationship can be greatly strengthened.

Touching—Within Orthodoxy, members of the opposite sex, except for spouses and immediate family members, do not touch each other. Many Orthodox Jews extend this custom even to casual contact such as a handshake. First, professionals should not misinterpret the failure to reciprocate a proffered handshake, or an instinctive withdrawal following contact, as personal rejection. Second, the sensitive professional should acknowledge that the patient may not be comfortable with contact, even during a routine physical exam. While the clinician should never presume an individual patient's practice without asking, he or she may begin by saying something like, "I know that men and women don't usually touch in your community. To check for X, I will need to touch your back and abdomen. Is there any way I can do this which will make you more comfortable?" Such a simple and honest acknowledgement of the patient's awkward position will be greatly appreciated and may reveal simple actions that can mitigate the problem.

Seclusion—Called *yiḥud* in Hebrew, many Orthodox Jews avoid remaining in a closed room alone with one or two members of the opposite sex outside of immediate family. While exceptions are usually made for doctor's offices and some other similar professional settings, the Orthodox patient in this position may still feel uncomfortable. When possible, this anxiety may be relieved by leaving the door ajar. In an inpatient setting, the clinician may elect to delay a patient visit until the patient's spouse or other visitor is present, in order to avoid complete seclusion with the patient. People who observe these rules are accustomed to a high degree of modesty and privacy. In a hospital or other institution where staff members enter and leave unannounced without the patient's invitation, the Orthodox patient may remain at elevated levels of anxiety and discomfort. Direct acknowledgement and appropriate attempts to help the patient better control the environment will often be greatly appreciated.

Dress and Head Covering—Most Orthodox Jews dress modestly. Men often wear suits while women make sure to cover their necklines, elbows and knees. Hospital garb with open backs often makes patients very uncomfortable. Men cover their heads with a *kippah* (Hebrew), *yarmulke* (Yiddish). When a patient is immobile, staff assistance in making sure that a male patient has his head covered is appreciated. Married women also cover their natural hair in the presence of men. Head coverings may include a wig (*sheitel*), hat, scarf (*tiḥel*), snood or headband. Women without their heads covered may feel especially vulnerable around male staff. In a hospital room, offering to step outside and provide the female patient with a minute to don her head covering will not only reduce discomfort but also affirm the clinician's desire to respect the patient's culture. Exploring creative ways to help a woman cover her hair when bandages or electrodes interfere also shows sensitivity and may help to build long-term trust.

Supporting Elder Patients

The Talmud teaches that the fragments of the shattered tablets of the Ten Commandments, which Moses broke at the base of Mount Sinai, were carried in the Holy Ark together with the new ones. This serves as a reminder that even when someone has lost much of his or her wisdom and capacity, the community must continue to honor and respect the person. This principle guides the Jewish response to the challenges and opportunities presented by aging and dementia.

> Rabbi Akiva said: "The Jewish people are like a bird. Just as a bird cannot fly without wings, so too the Jewish people can do nothing without their elders."
>
> TRADITIONAL RABBINIC TEACHING

With the loss of loved ones and memories, many elderly people begin to feel alienated from their past. Without hope and a vision of possible change, they also cannot imagine a brighter future. The elder can become trapped in an eternal present, with only a seemingly endless void ahead. For too many elders, that emptiness becomes filled with television or other numbing distractions. As pastoral care expert Rabbi Dayle Friedman and some others have observed, Jewish tradition offers an alternative: the *mitzvah*—religious duty. Americans are accustomed to relieving the elderly of obligations, not emphasizing them. Jewish law, to the contrary, exempts the elderly from religious requirements only in the very rare situations when their observance might pose immediate harm. Otherwise, Judaism views the elderly as having the same responsibility to worship God and contribute to others as anyone else. The Jewish theologian Abraham Joshua Heschel writes, "Advancing in years must not be taken to mean a process of suspending the requirements and commitments under which a person lives." Age does not diminish one's humanity; Judaism acknowledges this by expecting the participation of its elders in communal life.

An older Jewish person's performance of ritual acts of worship may help connect the elder to a rapidly fading past. When someone feels isolated, participating in activities that have been performed for thousands of years connects him or her to a broader community. Religious rituals such as prayer, lighting Sabbath candles and thanking God after a meal also offer hope and point toward a meaningful future. And they can give focus to an elder's otherwise relatively inactive days.

A Christian chaplain recounts the following story of his encounter with a Jewish hospital patient:

> I arrived to find several staff members very concerned. Mrs. B., a woman in her eighties, had apparently become worried that nobody would bring her upstairs for the Rosh HaShanah [Jewish holy day] service. She was out of her hospital gown and wearing a dress, waiting. Mrs. B. had emigrated from Eastern Europe following the war and served as a nurse for decades. She never had a family or many friends outside of her work. She was intelligent, determined, very strong for her small frame and spoke many languages. This hospitalization was difficult and, while always remaining polite, Mrs. B was consistently uncooperative with the medical staff.
>
> I offered to escort Mrs. B to the service on my own. I walked her arm-in-arm up to the service and sat with her, holding her prayer book, which she didn't need to look at once. During the moment for silent prayer, I read one of the prayers in English quietly

Propriety of Nursing Facility Care

The only one of the Ten Commandments with a reward attached to its observance is honoring one's parents. The reward that the Bible stipulates is "length of days," with the not-so-subtle hint that those who expect to be cared for in old age must care for those who are elderly now. Throughout most of Jewish history, the care was expected to be direct: spoon-feeding and washing one's parents, if necessary. However, the Talmud recognizes that sometimes it was better for a third-party to provide care as an agent of the child instead of the child personally providing direct care.

The great medieval Jewish thinker Moses Maimonides wrote, "If the condition of the parent has grown dire and the child is no longer able to endure the burden, he may leave his father or mother, go elsewhere, and delegate proper care of the parent to others." In a modern interpretation of Maimonides's ruling, leading contemporary scholar Rabbi Elliot Dorff writes, "[…] if the children cannot realistically care for their parents themselves or if the parents would be better off and happier living in their own home or in a facility for the elderly, then placing them in such a facility is not only permissible [according to Jewish law] but possibly the most desirable option, provided that the tone with which this arrangement is made and carried out is one of honor, respect, and ideally even love" (*Love Your Neighbor and Yourself: A Jewish Approach to Modern Personal Ethics*, Jewish Publication Society, Philadelphia, 2003, p. 140).

Judaism does not suggest one answer to all situations; rather, it encourages the elderly, their adult children, other caregivers and healthcare professionals to join together in a frank and honest exploration of the risks and benefits of all possibilities. Jewish tradition demands that children work to care for their parents but sets limits so that they do not fail to care for themselves and their families in the process.

to her…though I understand now that it wasn't necessary.

She stood for the whole service—a full hour. She out-stood even the young rabbi and cantor who needed to sit during the Torah discussion. She recited each word in Hebrew aloud. At one point, just for a moment, she cried softly. She was very happy to greet the rabbi at the end of the service.

Taking her back to her room afterward, I said, "You knew all your prayers…that's good!"

"Had good teacher," she said in a thick accent.

"I can tell you did," I said. "Who was that?"

"Mother…Father," she said.

When we got back onto the unit, everyone fussed over Mrs. B. "She stood longer than the rabbi and the cantor," I reported.

Several nurses raised their hands in triumph. "Way to go, Mrs. B!" they said.

In an institutional setting, clinical staff should work together with pastoral care professionals as early as possible in the care of the elderly, to identify ritual practices that may have significance for the elder and which the elder remains capable of performing. For both institutionalized elders and those living at home, health care professionals should be familiar with the resources the local Jewish community provides for the elderly, many of which include assistance with establishing routines for the performance of religious rituals.

For social work and chaplaincy services in the home, contact the Jewish Family and Children's Agency at www.ajfca.org, or by phone at (800) 634-7346.

For resources for elders and their caregivers to continue Torah study, holiday celebration and spiritual development at home or in an institution, see Hiddur: The Center for Aging and Judaism at www.hiddur.org or by phone at (215) 576-0800, and the Sacred Seasons program at www.sacredseasons.org.

Sacred Aging (www.urj.org/jfc/olderadults) is a project developed by the Reform Movement to provide support and resources for Jewish institutions and individuals coping with the challenges of aging. The Reform Movement also publishes a guide for adult caregivers, *That You May Live Long: Caring For Our Aging Parents, Caring For Ourselves*, Richard Address and Hara Persons, eds., UAHC Press, 2003.

IV. Providing Care at the End of Life

This chapter is intended to help caregivers understand the beliefs and rituals of Jewish patients and their families as death approaches. It describes the context in which many Jews understand death, and addresses clinical topics such as palliative care and hospice, advance directives and life-sustaining treatment. It also summarizes the most common Jewish beliefs about the afterlife. The single most important point for clinicians and other caregivers to bear in mind while reading this material is that there is no monolithic set of religious directives about Jewish beliefs on these subjects. In other words, while Jewish beliefs on these matters can be described and considered, they do not provide simple rules to follow for patient, family or caregiver.

Emotional Responses to Dying

Both traditional Jewish texts and contemporary Jewish practice recognize that as death approaches, a variety of emotional responses—intermixed, shifting, contradictory—may emerge among patients and family. Jewish teaching neither anoints nor abjures any particular emotional response but instead seeks to have patients and family accept and respond compassionately to the whole range of human responses.

> Life is pleasant. Death is peaceful.
> It's the transition that's troublesome.
>
> Isaac Asimov, well-known author

Finding Meaning as Death Approaches

One chaplain recounts:

> I visited Mrs. Schwartz regularly when she was hospitalized for chemotherapy treatments. As her disease progressed, her estranged father traveled from New England to make amends and say goodbye. Less than a week later her brother, who had converted to Christianity and rejected his family, traveled from California to care for his dying sister. As I was leaving the room following one of these visits, Mrs. Schwartz's hospital roommate beckoned me to sit by her side. She whispered, "Rabbi, I know I'm not supposed to say this, but I'm thinking about telling my family that this stupid tumor will kill me…just so we can kiss and make up like *they* are doing."

The sentiment expressed by Mrs. Schwartz's roommate echoes a longstanding Jewish belief that facing death provides an opportunity for growth, learning and acceptance. Judaism does not argue that suffering is good, nor does it minimize how difficult it is for people and their families to face death. Jewish tradition does, however, encourage people to acknowledge that they can control their response to suffering and, in so doing, may find opportunities for spiritual healing and development even when physical healing is no longer possible.

A rabbinic teaching recounts that prior to the time of the biblical patriarch Jacob, there was no illness. People simply died suddenly. Jacob, however, prayed to God to grant illness as a gift to humans so that we could know when death was coming and arrange our affairs—financial and spiritual—accordingly. Honestly facing the reality of death provides a catalyst to prioritize one's spiritual and emotional needs. When Jacob is preparing for death, he approaches his children saying, "Behold, I am about to die." As noted by author Rabbi Jack Reimer, this passage from scripture typifies the classical Jewish approach to death—direct and free from euphemism. Jacob does not attempt to shield his children from the pain of loss; instead, he invites them to share in the dying process with him. Judaism teaches that death is a natural and necessary aspect of divine creation. During times of illness, Jewish tradition places great emphasis on pursing effective treatments and praying for recovery, but it also acknowledges that not every disease can be cured, that medical technologies have their limits and that prayers for health may be answered with spiritual rather than physical healing.

Affirming the painful reality of impending death allows those involved to mobilize spiritual and emotional resources. The rituals and teachings of Jewish tradition remind the individual that, no matter how solitary and hopeless one feels, there is a community of people wanting to provide love, support and acceptance.

Fear of the Moment of Death

The Talmud teaches that death comes "like a gentle kiss from the mouth of God." Another story reports that when the ancient sage Rabbi Nachman visited his student Raba in a dream following the great teacher's death, Raba's first question was whether his master had suffered pain at the moment of death. Rabbi Nachman replied that he had not; it was as gentle as "removing a hair from a glass of milk."

On the other hand, the Talmud can be extraordinarily graphic in its depiction of the moment of death itself.

> It is said that the angel of death is covered with eyeballs. At a person's moment of death, the angel stands at the head of his sickbed with his sword unsheathed and a drop of bile at its tip. The person sees the angel, trembles, and his mouth falls open. The angel of death drops the bile into the dying person's mouth and he dies.

This fantastically descriptive passage gives voice to the common and timeless human fear of the act of dying itself, as distinguished from a more general fear of death. Some patients who are able to overcome fears about their impending non-existence nonetheless retain a profound fear regarding the moment of death. Though no data exists, some clinicians believe that this fear may be greater among Jews than among the general population. This may be partly explained by the fact that, as is discussed later in this chapter, most Jews are unlikely to be comforted by thoughts of "going to a better place."

Anger as Death Approaches

Jewish tradition asserts that change and growth are always possible, even in the waning hours of life. Jewish texts offer an ideal in which individuals find opportunities for spiritual growth, emotional healing and the reconciliation of broken relationships as death approaches. However, Judaism also acknowledges that death does not always come peacefully. Physical pain amplified by fear, denial, guilt or anger can create intense emotional turmoil. The impending death of a loved one can also reopen longstanding wounds and tensions within families. The following story, shared by the adult daughter of a dying woman, captures one family member's wish for a moment of intimacy colliding with a different, painful reality:

> My mother lay dying. My daughter Leah and I took turns lying in the bed with her so that she would never be alone, and I quietly sang her favorite Hebrew songs. My father, who himself was recovering from near fatal pneumonia, looked on helplessly. It was one of the few times in their 62 years of marriage that my parents slept in different beds. All his life, he had been the quintessential provider and family protector, and here he was, too weak and too scared to move.
>
> When it became clear that she would likely die in the next day or so, we wheeled my dad to her bedside. Quietly weeping, he placed her small hand in his palm and began to stroke it tenderly and rhythmically. "I love you, Bessie. I love you Bessie. You're the only woman I ever loved. Do you love me Bessie? Do you love me?" How could he feel unsure after a lifetime together? Of course, she loved him.
>
> "No!" she said sharply, and turned her head away. This must be a mistake. She must have misunderstood. It must be the morphine. Crying, he asked again: "Bessie, do you love me? This time, the "No" was sharper and louder.
>
> My father was bereft and we were stung—all of us. Over the last few days, there had been so much grace in the room, and now, totally unprepared for this sudden shift, and feeling my father's pain, I begged and admonished: "Mum, you can't say that to Dad, you can't say that. Please tell him you love him." But she never did.

Anger is a natural reaction when people realize that they can no longer fulfill their roles as parent, provider, teacher or spouse—essential elements of identity. Beyond the shame and guilt of not being able to support others, some people fear that their illness is actually burdening those they love. This cycle can lead to antagonistic behavior and angry outbursts. Jewish tradition does not instruct people to hide or inhibit the intense emotions which accompany the facing of death. Notably, there are no taboos in traditional Judaism against expressing anger even at God.

When a dying person rejects the care offered, family members and others may remind the patient explicitly that providing care at the end of life, far from being a burden, constitutes a great act of *ḥesed*—loving kindness—which family members *want* to do. Moreover, accepting care can rightly be seen as a gift the dying person is giving to those whom he or she loves. Thus the terminally ill may be not only passive receivers of care but simultaneous providers as well. By accepting care, they are serving the needs of their loved ones to provide that care. In fact, there is an even more stern formulation of this dynamic: Jewish law demands that even those who receive *tzeddakah*—charity—still have the obligation to give charity to others.

This tradition of bluntness, unrepressed anger and open conflict among Jewish family members may not be comfortable for some professional caregivers. Healthcare professionals must remember that they cannot compel specific types of behavior by dying patients and their families. Nor can they abandon patients or families who approach death in ways that make them uncomfortable. Instead, caregivers must endeavor to understand the cultural basis of this set of responses, and above all to remain present—even through a dying process which the patient or family seems to be making unnecessarily difficult.

For further treatment of these issues, see *Dying Well: The Prospect for Growth at the End of Life*, Ira Byock, Riverhead Books, 1997, and *Wrestling with the Angel: Jewish Insights on Death and Mourning*, Jack Reimer, Syracuse University Press, 2002.

Reluctance Regarding Palliative and Hospice Care

As people filed out following the Yom Kippur evening service I led in a hospital conference room, I noticed Mrs. Rubenstein, connected to her portable IV pole, crying in the back row. I sat next to her quietly for a long time before she spoke. When she was ready, she explained that she had just agreed, hours before the service, to accept a bed the following day at an inpatient hospice facility. She grabbed my hand, looked me in the eye, and asked, "Rabbi, I'm a Jew. I'm not supposed to give up like this, am I?"

This rabbi's story highlights the common misperception among many Jews that palliative care in general and hospice in particular are inconsistent with Jewish teaching against "giving up on life." Because there is a strong sense in Judaism that life and health should be pursued with great vigor, Jewish patients may be especially reluctant to consider hospice care. This section considers how the values underlying palliative care and hospice are in fact consistent with Jewish values at the end of life.

The terms "palliative care" and "hospice care" are poorly understood not only by patients but also by many healthcare professionals. Clinicians may want to emphasize some of the following talking points when explaining these concepts to Jewish patients and families who may harbor significant misconceptions about Jewish perspectives on the matter.

Regarding palliative care:

- Jewish tradition emphasizes the profound interconnection between healing of the body and healing of the soul—*refuat ha-nefesh* and *refuat ha-guf*. This dovetails well with palliative care, which addresses a patient's emotional and spiritual needs as well as physical concerns. Palliative care medical specialists work closely with social workers and chaplains to provide highly integrated care.
- Palliative care specialists work closely with the patient's admitting or primary care physician in same way any other specialty service would. Instead of reducing medical care, the involvement of a palliative care team adds to the patient's overall treatment.
- Many people mistakenly assume that palliative care means shortening life, which is why they are resistant. Patients and families need to be reassured that palliative care does not interfere with curative treatment. Moreover, some data suggests that palliative care prolongs life in addition to improving its quality.
- Proper palliative care in a Jewish context is careful to avoid any intervention which might actively hasten death.

For more discussion of palliative and hospice care for Jews, see *Embracing Life & Facing Death: A Jewish Guide to Palliative Care*, Daniel Brenner, Tsvi Blanchard, Joseph Fins and Bradley Hirschfield, CLAL, 2002, and *The Jewish Hospice Manual: A Guide to Compassionate End-of-Life Care for Jewish Patients and their Families*, Maurice Lamm and Barry M. Kinzbrunner, National Institute for Jewish Hospice and VITAS Healthcare Corporation, 2003.

For resources about specifically Jewish hospice programs, see The National Institute for Jewish Hospice at www.nijh.org or by phone at (800) 446-4448.

For general information about hospice, see The National Hospice and Palliative Care Organization at www.nhpco.org or by phone at (800) 658-8898 and The Hospice Foundation of America at www.hospicefoundation.org or by phone at (800) 854-3402.

Palliative Care and Hospice: Working Definitions

The terms palliative care and hospice are not always used with precision even within the healthcare community, a problem that contributes to public misunderstanding about them. This guide uses the terms in the following specific ways:

- **Palliative care** is a broad field of medical and related care, provided in both inpatient and outpatient settings. It brings medical, social, emotional and spiritual concerns into the realm of patient care. Rather than attempting to treat disease directly, palliative care focuses on the physical and emotional impact of the disease, and on the family as well as the patient. Palliative care does *not* require ending treatment of disease; in fact, curative and palliative care are often offered concurrently. Palliative care is generally available regardless of prognosis or estimate of mortality.
- **Hospice** is a subset of palliative care, specific to patients at the end of life. The election of hospice by a patient usually implies the forgoing of any further attempts at treatment with curative intent. Eligibility for hospice is usually limited to patients who are expected to die within six months. Hospice care is most often provided at home but is also offered in many acute care, nursing or hospice facilities.

Regarding hospice:

- While Judaism helps people to maintain hope even as death is approaching, Jewish tradition does not encourage false or unrealistic hope. Contemporary hospice care reflects the values that Judaism has traditionally demanded of caregivers at the end of life: pain management, maximizing function, respecting dignity, facilitating lucidity and providing peace. So, accepting hospice when curative treatment is no longer effective becomes a means not to abandon life but to hold on to it while maintaining appropriate hope.
- By treating symptoms and pain without introducing invasive procedures unlikely to benefit the patient, hospice allows the dying person to use his or her final days to complete the great spiritual, emotional and relationship tasks at hand in a setting better-suited to the project. In this way, hospice allows the individual to reaffirm life, as Jewish tradition demands when death is approaching.
- It is often Jews without a strong religious affiliation who are most resistant to hospice. They tend to be unaware of many Jewish teachings that call for accepting the reality of death when it is imminent. All movements in American Judaism recognize a place for hospice at the end of life. When religious concerns present as the primary obstacle to accepting hospice, a patient and family should be directed to a certified chaplain or local rabbi with appropriate training and relevant experience.

Attitudes Toward Advance Directives

Many people are confused by the terms "advance directive," "medical directive" and "living will," and do not understand the parameters of a do-not-resuscitate order (DNR). Also, because Jewish tradition demands the pursuit of aggressive treatment—an assumption explored in the following section—some Jews are especially reluctant to enter into a conversation about advance directives. The fact, however, is that *there is no Jewish objection to advance directives* and each movement within Judaism has drafted model advance directive templates (see the list of resources on this page) which guide the individual through religiously appropriate decision-making.

Preparing an advance directive, and appointing a proxy to ensure that the directive is followed, present an opportunity for a person to explore and articulate what values are most important. In this way, the process of discussing an advance directive dovetails well with the emphasis traditional Judaism places on evaluating one's priorities and articulating one's beliefs when preparing for death.

Conversations about advance directives typically tend towards what one does not want: "I don't want to die hooked up to a machine." "I don't want to die in pain." While these concerns are crucial, Jewish tradition concerning the end of life directs the individual also to discuss what he or she *does* want. There are no check boxes on the standard forms for most of these, but caregivers—family, proxy, rabbi, and clinician—can assist patients in this regard by encouraging them to consider a number of the following questions:

- When you think about your own dying, what concerns you the most?
- What might give you the most peace of mind?
- Do your religious beliefs lead you to any specific concerns?
- Who do you want present at the end?
- What do and do you not want to be told about the imminence of death?
- What music, prayer or ambience would you want?
- What do you want told to others, and specifically to whom?
- Generally, how and with whom would you like to spend your final days?

For advance directive templates consistent with the theological principles of each major movement of Judaism, see:

Conservative:

Jewish Medical Directives for Health Care
www.rabbinicalassembly.org/teshuvot/docs/19861990/mackler_care.pdf

Orthodox:

Living Will, Rabbinic Council of America
www.hods.org (click on "*Halakhic* Issues," then "Documents")

Living Will, Agudath Israel of America
www.jlaw.com (click on "*Halakhic* Forms," then "General Form" under the heading: "*Halakhic* Living Will")

Reform:

A Time To Prepare: A Practical Guide for Individuals and Families in Determining One's Wishes for Extraordinary Medical Treatment and Financial Arrangements, ed. Richard Address, UAHC Press, 2002.

In this way, instead of discussions about an advance directive seeming to constitute a rejection of Jewish end-of-life values, the process can guide the individual through the steps that Jewish sages have encouraged for centuries.

Treatment Decisions Near the End of Life

Medical care at the end of life is an issue of active debate in all corners of the Jewish world today. A wide range of opinions exists and the level of one's ritual observance proves a very poor predictor of decision-making priorities at the end of life. This section summarizes Judaism's mainstream views and introduces healthcare professionals to the basic concepts within Judaism that inform the debate.

The Bible commands that all Jews "choose life," which marks the basis for Jewish tradition's profound emphasis on pursuing good health. For example, while the Jewish dietary restrictions and rules about the Sabbath are observed meticulously in some communities, Jewish teaching is clear that one need not hesitate to violate *Shabbat* or almost any other law when necessary to preserve life or health.

Throughout most of Jewish history, good health and length of days were indivisible. Consequently, Jewish tradition generally encouraged any life-saving measure that has a reasonable chance for success, even over patient objections. In secular bioethics terms, traditional Judaism has always prioritized beneficence over individual autonomy.

> When one is in the final stages of the dying process, others should not pester him to retain his soul. Not only is this not possible to do, but if only a few more days are produced by the pestering, those days will be days of suffering.
>
> Sefer Hasidim,
> 13th Century Book of Jewish Practice

In the modern era, however, medicine has developed technologies which can lengthen life without simultaneously promoting overall well-being. In considering the appropriateness of these technologies, Jewish law makes three primary distinctions:

- between a person who is actively dying with no chance of recovery and a person who may continue to live
- between withholding and withdrawing treatment
- between interventions which hasten death and interventions which serve as an impediment to natural death.

Of course, these distinctions often break down and blur together in practice, so specific situations must always be assessed on an individual basis. The following discussion of particular end-of-life issues is intended to illuminate the ways in which these basic distinctions affect treatment decisions. In the end, caregivers must understand that Jewish law provides no clear and simple rules to follow regarding these immensely difficult decisions.

Life Support

Classical Jewish law asserts that when a person has a chance to live, even with a reduced "quality of life," aggressive treatment with a proven, reasonable probability of success—called in Hebrew *refuah bedoka*—is obligatory unless the treatment itself introduces new medical risks at a level comparable to the disease itself. Jewish law further recognizes that death is natural and the dying process begins long before the last breath is drawn. An "actively dying person" is known in Hebrew as a *goses*. However, understandings vary widely of who exactly is a *goses*; some definitions include only those expected to die within 72 hours while the most expansive opinions include all those diagnosed with a terminal illness, regardless of life expectancy.

Ancient rabbis understood well that human beings could not stop the process of death once it has begun. Consequently, when someone becomes a *goses*, the imperative for aggressive treatment ends. In fact, while nothing may be done to actively hasten death, any medical treatment or other intervention which serves as an "impediment to death" should be withheld from the *goses*, even if it causes the patient to die more quickly. Rabbi Moses Feinstein, a 20th-century Orthodox scholar, writes, "even routine hospital procedures such as drawing blood and taking temperature have no place in the final hours of a patient's life." Contemporary rabbis today disagree vehemently about which life-sustaining treatments, e.g. dialysis or mechanical ventilation, are to be classified as "impediments to death," allowing them to be withheld from someone who is actively dying with no chance of long-term recovery. Various opinions on all of these issues can be found across each movement in Judaism.

These issues are further complicated by the fact that Jewish tradition affords great weight to the distinction between withholding and withdrawing treatment, despite the medical community's general acceptance that there is no moral distinction between them. For example, no Jewish authority argues that life-support measures such as mechanical ventilation or dialysis are necessary absent a reasonable expectation of success. Again, the imperative to treat applies *only when the treatment is likely to reverse the disease, improve function or provide comfort to the patient.* However, once an on-going life-sustaining therapy has been introduced, its withdrawal becomes problematic. Withdrawal is prohibited according to some rabbinic opinions while other rabbis rule that, in such a case, the person receiving life-support should be considered a *goses*, even though he or she might thereby remain alive for an

extended time. In this interpretation, the intervention constitutes an unnecessary impediment to the dying process and should be removed.

Most Jews, even those with a strong connection to traditional observance, are usually ill-informed about the nuances of Jewish law surrounding end-of-life issues. In practice, this often translates into the gravely oversimplified belief that Judaism mandates maximizing length of life at all costs. Individuals and families in this situation who are affiliated with a synagogue should be encouraged to discuss these decisions with their rabbi. A pastoral care referral can be made for those who do not have their own rabbi.

Do-Not-Resuscitate Orders

Treatment that cannot reverse the underlying cause of an illness or provide comfort to the patient is never obligatory. So, when a patient is already a *goses*—in an actively dying state—before a cardiac arrest, cardio-pulmonary resuscitation may be withheld because it interferes with the natural dying process. In these situations, rabbis across all movements generally agree that do-not resuscitate (DNR) orders are consistent with Jewish law. Many rabbis also permit the withholding of cardio-pulmonary resuscitation—and thus would approve of a DNR order—in a broad range of other instances when there is little evidence that the intervention is likely to lead to improved health or function.

Artificial Nutrition and Hydration

The greatest area of debate in contemporary Jewish end-of-life ethics revolves around artificial nutrition and hydration. While Jewish law permits patients to decline medical treatment which has no reasonable chance of success, it does not allow a person to refuse to eat. The question thus becomes whether artificial nutrition and hydration should be considered food or medical treatment. The issue is complicated, and remains unresolved in most Jewish communities. Interestingly, all authorities agree that, because artificial nutrition does not pass through the mouth, it is exempt from all Jewish dietary restrictions. The fact that this nutrition need not be kosher suggests that it is not considered food in the ordinary sense of the term.

Many rabbis view artificial nutrition and hydration as an "impediment to death" and thus not appropriate in situations where the patient is actively dying. They point to the growing medical evidence which suggests that dehydration may actually be beneficial to some terminal patients as it reduces sensations of pain and avoids common complications such as swelling of the legs and abdomen as well as lung congestion. For many rabbis, this understanding extends to patients with advanced dementia for whom there is no evidence that artificial nutrition improves function, comfort or survival. Most of these same rabbis would, however, argue for artificial nutrition when a patient is in a permanent vegetative state and not actively dying.

Other rabbis argue that, except in cases where it is medically contraindicated, tube-feeding constitutes standard treatment which must be provided to everyone, including those actively dying. However, many of the opinions that mandate artificial nutrition and hydration allow for exceptions when the patient explicitly refuses or consistently attempts to remove the tube. Many other opinions attempt to find compromise positions among these extremes.

In practice, the difficultly surrounding this decision for most family members is not the Jewish legal arguments—there is enough weight on each side of the debate to justify either decision—but rather the non-sectarian, simply human crisis of not feeding a loved one. In such cases, a pastoral care referral is indicated. Certified chaplains can help family members process their feelings of helplessness and explore alternative means of providing care for the patient that remain consistent with the goals of treatment.

Assisted Suicide

Jewish tradition places great emphasis on the importance of aggressive pain management, and as discussed above, once the dying process has begun, Jewish tradition also demands the removal of artificial impediments to death. However, active intervention with the primary purpose of hastening death is not sanctioned under Jewish law. Nonetheless, a Jewish patient who is considering assisted suicide deserves comprehensive emotional and social support, which includes a complete spiritual assessment from a trained chaplain.

Jewish Rituals Prior to Death

An elderly woman came before Rabbi Yose ben Halafta and said, "Rabbi, I no longer taste food or drink. My limbs are heavy. I would be happy to leave this world." The rabbi said, "Are you interested in your daily life? Is there nothing you do that is part of a routine which keeps you going?" The elderly woman replied, "I go to synagogue every day." The rabbi said, "When you are too weak to live, abandon

An Attempt at Life-Support Resolution in Israel

Attempting to resolve some of the problems that follow from a prohibition against withdrawing life support, a recent law in Israel requires all mechanical ventilators to be set on 24-hour timers. The decision to reinstate treatment must be made deliberately each day. Thereby, without requiring active withdrawal by the hands of the physician, the same result of removing the patient from life support can be reached by passively not resetting the timer and thus accord with even the strictest opinions in Jewish law.

this practice." The old woman followed the rabbi's advice and three days later, she died.

TRADITIONAL RABBINIC TEACHING

Letting go of life, physically and spiritually, is a natural process that Judaism views as holy. Jewish rituals prior to death seek to gently guide individuals through this sacred process. As death approaches, Jewish tradition teaches one to reflect on the life he or she has lived, to make amends for any misdeeds, to pass on wisdom gained from experience and to say goodbye. The most widely observed ritual prior to death is to recite a prayer of confession known as the *vidui*. Its form is familiar to religious Jews because of its similarity to the communal confession recited throughout *Yom Kippur*—the yearly Day of Atonement. However, when recited at the deathbed, the prayer is personal rather than communal. It provides the dying person an opportunity to acknowledge that he or she is imperfect and to request forgiveness.

The *Vidui*—Confessional Prayer Before Death

My God and the God of my ancestors, please accept my prayer and do not turn away from me. Forgive me for all the times that I have disappointed You throughout my life. I acknowledge my sins and misdeeds. Through my suffering, may I find atonement for my shortcomings. Against You have I sinned.

May it be your will, My God and the God of my ancestors, that I sin no more and that you grant healing—healing of the body and healing of the soul—to me together with all those who suffer.

I acknowledge before you, My God and the God of my ancestors, that my healing and my death are in Your hands. If it should be that I die, may I find atonement for all my sins, errors and transgressions before You. May you accept me into Your eternal kingdom.

Protector of orphans and guardian of widows, may my family and all those who love me find comfort in your presence. In your hands lies my soul.

Hear, O Israel: The Lord is our God; the Lord is One.

The Halakhic Organ Donors Society (www.hods.org, 212-213-5087) can connect individuals with well-respected local Orthodox rabbis trained in this issue. The website also provides detailed information emphasizing the permissibility in Jewish tradition to donate organs.

For additional information about end-of-life issues from the perspective of each movement in Judaism, see:

CONSERVATIVE:

Matters of Life and Death: A Jewish Approach to Modern Medical Ethics, Elliot Dorff, Jewish Publication Society, 2004.

ORTHODOX:

The Ecyclopedia of Jewish Medical Ethics, ed. Avraham Steinberg, Feldheim Publishing, 2003.

REFORM:

A Time To Prepare: A Practical Guide for Individuals and Families in Determining One's Wishes for Extraordinary Medical Treatment and Financial Arrangements, ed. Richard Address, UAHC Press, 2002.

Organ Donation

In the early years of organ donation, significant resistance developed in religious Jewish circles. Some rabbis argued that a clinically brain-dead person whose heart was still beating remained alive according to Jewish law; consequently, the harvesting of organs constituted murder. Others, who accepted that brain-death means death according to Jewish law, still had concerns about the removal of organs because, as will be discussed later, Jewish tradition mandates that a body be buried intact. This latter concern was quickly addressed, however, as rabbis witnessed successful transplants leading to recipients living long and meaningful lives. While respect for the body's integrity is one of the highest principles in Jewish tradition, the imperative to save human life was viewed as paramount.

Over time, the acceptance of organ donation as consistent with Jewish law has become widespread, though not universal. In most Jewish circles, the claim that organ removal is tantamount to murder no longer stands. One of the most compelling arguments is that Jews who have no objection to receiving donated organs would be hypocritical if they did not also approve of donating organs. In Israel, even the strictest religious communities have come to accept the Israeli Chief Rabbinate's endorsement of organ donation. In North America, the Conservative, Reconstructionist and Reform movements and some elements of modern Orthodoxy have arrived at this position; however, ultra-Orthodox communities in North America are generally more reluctant to embrace organ donation.

Jewish authorities are also actively debating the permissibility of administering heparin, which is derived from animal tissue, to a patient who is not clinically brain-dead prior to withdrawing life-support for the sole purpose of increasing the likelihood of a successful transplant at the risk of hastening death.

The early trepidation about organ donation and the refusal to accept it even today in some corners of the Jewish world often lead many well-intended Jews to mistakenly imagine that there is a Jewish prohibition against it. A knowledgeable rabbi should be brought in to discuss the issue with families when religious values present as the primary obstacle to consent.

Although the *vidui* is not considered a mandatory ritual, many dying Jewish patients, even those who do not believe in God, find reciting the prayer to be a meaningful spiritual exercise. Immediately prior to death, some people feel tremendous guilt for the pain they are causing to others by their departure and for leaving family members behind. When this is the case, reciting the *vidui* surrounded by loved ones can serve as a public absolution. Even if family members do not say a word during the ritual, their presence confirms their acceptance of the patient letting go and saying goodbye. Many Jews, religious and non-religious both, also value the prayer—particularly the closing line, which is the central Jewish prayer known as the *shema*—as an assertion of their bond to the Jewish people. Frequently, people augment the formal liturgy by adding their own words of affection or benediction at the end.

In order that a suggestion that the *vidui* be recited is not misunderstood by the patient as an abandonment of hope, Jewish teachings suggests that someone present reassure the dying person that "Many have said the *vidui* and not died. Many have not said the *vidui* and died." The teachings go on explain that someone who cannot say the *vidui* aloud should say it in his or her heart. If one is unable to recite it altogether, another person may recite it on his or her behalf.

Though no rabbi is necessary, most Jewish patients prefer the comfort of a rabbinic presence during this ritual. If the dying person is not in contact with a rabbi of his or her own, the medical staff should make a pastoral care referral as early as possible so staff chaplains can ensure that a rabbi or Jewish chaplain arrives in time to help with the *vidui* ritual.

Ethical Wills

Rabbinic literature is replete with the deathbed narratives of great sages. Often, great teachers of Torah die surrounded by their students while offering final words of wisdom or reiterating core teachings. Such stories remind the reader that someone who is dying remains a full human being with important wisdom to offer. They further teach that one's values can live on through others even after one's physical existence has ended.

Toward the same purpose, there is a tradition within Judaism of ethical wills, which are documents intended to pass on one's spiritual legacy as one faces death. There is no formal template; the only requirement is that they be a genuine reflection of the author's values. An ethical will may be written as a letter that offers spiritual and practical advice from a parent to children or a specific child, or it may aim at a broader audience, describing who the author is and what he or she stands for. The process empowers the writer who actively chooses how to be remembered.

Someone drafting an ethical will may want to include

- personal narratives
- childhood experiences
- stories about parents, siblings or lovers
- observations about how the world has changed during the author's lifetime
- moments of personal achievement
- points of great pride, unresolved grief or lingering regrets
- important life lessons
- blessings for those left behind and statements of love or forgiveness.

In sum, an ethical will is an opportunity to define what one believes in most strongly and to explain how such beliefs were formed. Regardless of the final product, the process of gathering these thoughts and exploring these issues directs the dying person to evaluate his or her life and provides a final opportunity to say what still needs to be said.

Many chaplains and hospital-based social workers are trained in life-review techniques. While this process does not normally produce a final document like an ethical will, it may permit the engagement of a dying Jewish patient in many of the same conversations. If the patient then wishes to transform his or her thoughts into an ethical will, a pastoral care referral should be made to the patient's rabbi or a Jewish chaplain.

For ethical wills from Jewish tradition, see *Hebrew Ethical Wills*, Israel Abrahams, ed., Jewish Publication Society, 2006. For assistance in drafting an ethical will, see *So That Your Values Live On: Ethical Wills & How to Prepare Them*, Jack Riemer & Nathaniel Stampfer, eds., Jewish Lights Publishing, 1994.

The Afterlife

One chaplain recounts:

> From my first visit, Mr. Klein made clear that his wife was the religious type and he was the "rational" one in the family. He had a strong Jewish ethnic identity and was proud that one of his children had become the principal of a Jewish school; yet, he reminded me often, religion wasn't for him. As usual, CNBC blared from the television overhead and Mr. Klein began our visit by giving me investment advice. As I directed the conversation towards Mr. Klein's experience of his illness, he acknowledged that his death was approaching faster than he would prefer. After a long pause, the confident market analyst dropped his eyes and sheepishly asked, "Rabbi, do we believe in heaven?"

> I don't believe in the afterlife, although I am bringing a change of underwear.
>
> WOODY ALLEN

Many modern Jewish theologies de-emphasize what happens after death and remind adherents that Judaism focuses on making the world a better place in the present, not passively waiting for some future resolution. Nevertheless, even many of the most secular of Jews, as dying approaches, will question if death really marks a complete end to life.

Jewish tradition provides no simple answer. The Hebrew Bible seems profoundly disinterested in the afterlife. The few passages which do address it generally imagine a realm in which souls rest peacefully with no conscious thought. Many later Jewish sages spoke of *olam ha-ba*—the World to Come. One ancient Jewish source made clear that only the most sinister Jews do not have a share in the World to Come; entry is not limited to saints. For some, the World to Come involves bodily resurrection and physical pleasures. Others are more strongly influenced by Hellenistic ideas of a sharp divide between body and soul: while the body decomposes, physical presence becomes irrelevant and the soul lives eternally, cleaving to the divine presence. Some sources imagine a waiting period during which the disembodied soul is purged of any sins by the prayers of mourners before final acceptance into God's kingdom.

Later rabbis make various complicated efforts to combine a view of physical resurrection with a belief in the immortality of the soul. In the middle ages, some mystical thinkers introduced concepts of reincarnation into Jewish thought; the soul transmigrates until it has completed its task of restoring holiness to the divine creation. The great Jewish philosopher Moses Maimonides listed a belief in the afterlife as a core Jewish principle but he remained silent as to its specifics. His view seems to be that Jews must hold hope for an afterlife, but there is no dogma about what precisely it will be. Jewish tradition generally recognizes that mortals, by definition, cannot know what will happen after death and any definitive statement about what it consists of amounts to hubris.

Jewish tradition teaches that people do good deeds on this earth simply for the sake of doing good, not to earn some future reward. However, hope that existence continues in some altered form following death is an essential, if undefined, tenet of Jewish doctrine. The lack of definition or specific imagery may cause anxiety for some as death approaches, and patients may seek the counsel of a rabbi to help address their uncertainty.

For more concerning Jewish views of the afterlife, see *The Death of Death: Resurrection and Immortality in Jewish Thought*, Neil Gillman, Jewish Lights Publishing, 1997, and *Jewish Views of the Afterlife*, Simcha Paull Rafael, Jason Aronson Publishing, 1996.

V. Traditional Practices Immediately After a Death

This chapter is intended to help caregivers understand Jewish customs and beliefs during the period between death and burial. It explains traditional practices for handling and burying the body, describes the protocol for a Jewish funeral and discusses particular issues related to suicide and perinatal death. As with all other rituals, the degree to which each of these practices is adhered to varies considerably among Jews of different levels of religiosity and organizational affiliations.

Conduct at the Moment of Death

A Jewish chaplain recounts:

> I was paged to the cardiac ICU. When I arrived, I found Mrs. Gottbaum wailing on the floor by her late husband's corpse. Though his condition had been severe, neither the staff nor the family was expecting Mr. Gottbaum to die so soon. Throughout his hospitalization and probably throughout their long life together, Mrs. Gottbaum had been a constant presence at her husband's side.
>
> After spending several nights in the ICU lounge, she had gone home to shower and bring pictures of their two dogs to place at the bedside. During this time, he died. Mrs. Gottbaum squeezed my arm and cried that she had not been able to say goodbye. She had promised she would never abandon her husband and she worried that, by going home for a few hours, she had failed to keep her word.
>
> Mrs. Gottbaum knew the tradition that a Jewish corpse is not left unattended prior to burial. I explained that this was so because Jews believe that the soul remains present, hovering over the body after death. I suggested that she speak directly to her husband's soul, express her regret that she was not in the room when he died, say the goodbye that she wanted to say, and display the dog pictures as a reminder that he is not alone.

While Jewish tradition recognizes that death marks the beginning of a separation between body and soul, that separation is not considered complete until the body is buried. From the moment of death until burial, the soul may have left body, but it has not traveled very far. Many Jewish theologies imagine that the soul lingers, somewhat confused, in the room where the corpse lies. For this reason, Jewish tradition demands utmost care that nothing is done in the room which might show disrespect for the deceased. For example, casusal or unrelated conversation is prohibited. Around the corpse, discussion must focus exclusively on funeral arrangements or praise for the character of the deceased. Mourners may say what had been left unsaid when the person was alive; Jewish sages believe the deceased's soul may be especially receptive to words of closure during this period. This does not mark the final time that words may be spoken to the deceased, but it may afford opportune moments for goodbyes. Observant Jews do not eat, drink, smoke or even perform most religious rituals in the same room as the corpse lest the soul of the deceased feel jealous that he or she is no longer able to do so as well.

Some Jews follow traditions such as opening a window or laying the corpse on the floor with the feet pointing towards the door in a symbolic effort to help the soul leave the room and begin its journey towards the divine realm. Similarly, candles may be lit, mirrors may be covered and standing water may be discarded with the intent of removing any obstacles to the soul's departure. These longstanding customs have become helpful metaphors for saying goodbye and, as such, should be encouraged and supported when initiated by mourners.

From the moment of death until burial, observant Jews arrange for at least one Jewish person to remain in the room with the corpse, or immediately outside. This practice—called *shemirah* in Hebrew—ensures that the deceased's soul does not feel abandoned before it is able to separate from the body completely. Even Jews who no longer hold this view of the body and soul may still find meaning in the longstanding practice, or may observe it without understanding its exact purpose. Jewish funeral homes and non-sectarian funeral homes that serve a Jewish clientele usually have a list of people in the community on call to stay overnight with the body when the mourners are not able to. The designated person sleeps no more than twenty minutes every hour and spends at least twenty minutes every hour reciting Psalms on behalf of the deceased.

Many traditionally inclined mourners recite the following blessing immediately after a death or upon first hearing the news that someone has died:

> *Baruch ata Adonai Eloheynu melech ha-olam, dayan ha-emet.*
>
> (Blessed are You, Lord our God, King of the Universe, the true judge.)

At a time when many feel most distant from God, this prayer reminds the mourner that he or she has not been abandoned by God, while simultaneously acknowledging the magnitude of what has happened.

Medical staff attending to an observant Jewish patient who has died should allow family members or their designees to handle the body without interference. If no one is present, staff should:

- Make sure that the eyes and mouth are closed as quickly as possible.

- Straighten the body if it lies in an awkward position.
- If any linens or clothes have the patient's blood on them, they should be placed by the body's feet.
- Disconnect machines and cut tubes. *However, nothing should be removed directly from the body.* As discussed below, normative Jewish practice demands that the body be buried in its entirety, including even trace amounts of blood or other tissue. Consequently, no tube should be removed if there is a chance that doing so could cause blood to spill. If the family is arranging a traditional Jewish burial, the funeral home will ensure that those preparing the body remove foreign objects in a way that accords with Jewish law.
- Gently cover the entire corpse, including the face and extremities, with a clean bed sheet.

Lamenting and Grief

Immediately after a death, mourners enter a transitional period characterized by the raw intensity of grief. Jewish tradition provides a name for this phase—*aninut*, lamenting. This name reinforces to the mourners that this period constitutes part of the natural progression of grief and that it will eventually give way to other emotional states. The mourners themselves at this time are called *onenim* (*onen*, singular), lamenters. Judaism teaches that there is no right or wrong emotion—rage, overwhelming sorrow, numbness, relief—for mourners at this time. An ancient text declares, "Lament your dead! Do not hide your grief! Do not restrain your mourning!" Outsiders during this time may provide comfort through their presence, but active consolation or any effort to explore the grief is not appropriate until after the funeral.

> Do not try to comfort your fellow while the body of the deceased lies before him.
>
> — THE TALMUD

Prior to burial, the one obligation that Jewish tradition demands of mourners is *kevod ha-met*—honoring the dead. Mourners are exempt from all other religious obligations such as prayer, charity and Torah study during this time lest they interfere with the mourner's primary task, ensuring the highest level of honor and respect for the deceased. Traditionally, mourners refrain from sexual activity, personal grooming, conducting business, drinking alcohol and eating meat. In this way, mourners are set apart from the rest of the community and are directed to confront their loss.

Practices Related to Burial

Time Frame for Burial

One of the most well known Jewish customs, intended to show honor for the dead, is the tradition of burial as soon as possible. In ancient times, an unburied body was subject to thievery and looting. Because Jews are not traditionally embalmed, unburied bodies were also subject to rapid decomposition. Consequently, delaying burial came and continues to be viewed as an act of disrespect towards the deceased. In some ultra-Orthodox communities, when someone dies in the morning or early afternoon, the funeral and burial may take place before sundown. More common among Jews today, the funeral is scheduled for the following day.

One effect of a quick burial is that mourners are not left alone in the initial stages after a death, to be overwhelmed by grief. Instead, the rush to make funeral arrangements provides specific tasks and focusing mechanisms that work to temporarily bind the emotions of grief until they can be managed with greater perspective. When a death occurs on Friday, though, the funeral is postponed until Sunday because it may not take place on the Sabbath (see Death on the Sabbath, right). If loved ones must travel a great distance, the funeral may be delayed up to 48 hours so that they may attend. However, funerals are not traditionally postponed for the convenience of mourners or for other social reasons.

For information about the hours immediately after a death, see *The Jewish Mourner's Handbook*, ed. William Cutter, Behrman House, Inc., 1992.

Autopsies

Following from the principle that the corpse is divine property, the body should not be altered by humans in any way after death. Consequently, Jewish law prohibits autopsies in most situations. Exceptions are made when an autopsy is required by civil law or when the knowledge gained from an autopsy is reasonably expected to provide information that can save the life of another human being. When an autopsy is performed on an observant Jew:

- It should be completed as quickly as possible so that burial may take place without undue delay.
- All fluids, tissue, and other body parts removed for inspection should be collected, preserved and returned, as they will be buried together with the body.

Because of the need to prepare the body for burial so quickly, it is essential that medical staff caring for a Jewish patient who has died expedite the paperwork necessary for the death certificate, so that the funeral home may retrieve the corpse immediately.

Caring for the Dead—*Taharah*

The traditional Jewish practice is to prepare the body for burial through a process known as *taharah*—purification. During *taharah*, the body is washed, dressed, ritually purified and placed into the coffin. This ritual used to be observed primarily in Orthodox communities, but in recent decades many non-Orthodox Jews have reclaimed the tradition. *Taharah* is most often performed in the funeral home by Jewish volunteers who serve as part of a *ḥevra kadisha*—holy society.

Respecting the Jewish value of modesty, only *ḥevra kadisha* members of the same gender as the deceased prepare the body. They begin by thoroughly washing the corpse, cleaning the fingernails, de-impacting the bowels and stopping any blood, at all times exhibiting utmost respect for the deceased. The ritual begins with solemn prayer, and usually at least one member of the *ḥevra kadisha* continues to recite prayers throughout the *taharah*. Only conversation about the process itself is permitted. In an effort not to treat the body as an object, nothing is passed over body; rather, volunteers working on opposite sides of the body walk around in order to hand items such as scissors or cloths to each other. To maintain the dignity of the deceased, only the area of the body being treated is uncovered.

The washing may take up to an hour, much longer in cases of traumatic death. Once the physical washing is complete, the *ḥevra kadisha* turns to spiritual cleansing. Water from a *mikveh*—Jewish ritual bath—is poured over the corpse in a continuous stream so that all parts of the body are touched by it. Upon completion, the body is declared *tahor*—pure. Ritually, this symbolizes that the dead person is no longer burdened by his or her misdeeds and shortcomings while alive. The soul is free to leave the world unencumbered and enter the divine realm.

The members of the *ḥevra kadisha* then dress the body in *tachrichin*—burial shrouds. They are made of plain white linen and have no pockets—a reminder that a person takes nothing from here into the next world. All Jews who observe this practice, regardless of status or wealth, appear the same in death, wearing identical simple shrouds. Also, no mourning family needs to worry in their grief about what kind or elaborateness of clothing is appropriate for burial; only the most basic dress is permitted.

Once dressed, the volunteers sprinkle earth from the land of Israel into the coffin. Some *ḥevra kadisha* organizations also observe various local customs, such as applying a mixture of egg-whites and vinegar to the forehead of the deceased, resting pottery shards over the eyes and mouth, or placing wooden sticks in the hand. The coffin is sealed at the end of the ritual and is not opened again. The ritual concludes with the volunteers reciting additional prayers on behalf of the deceased, requesting divine forgiveness and acceptance into the eternal kingdom. Most *ḥevra kadisha* members also perform a ritual of seeking forgiveness from the deceased for any unintentional act of disrespect during the *taharah* process. Volunteers consistently describe the process as

For stories by *ḥevra kadisha* members, and more information about the *taharah* process, finding and joining a *ḥevra kadisha*, and selecting funeral homes, see *Dignity Beyond Death: The Jewish Preparation for Burial*, Rochel Berman, Urim Publications, 2005, and www.jewish-funerals.org.

Death on the Sabbath

The Jewish Sabbath (Hebrew: *Shabbat*, Yiddish: *Shabbos*) extends from sundown Friday evening through an hour after sundown on Saturday. Observant Jews refrain from all manner of "work" during this time, including writing, the use of electricity or motorized transport, spending money and even carrying objects from inside to outside. A funeral may not take place on the Sabbath, nor may most funeral preparations be made.

When a death occurs on the Sabbath, strictly observant families will not contact the funeral home until Saturday evening. Even if the family members are willing to use the telephone, many Jewish funeral homes will not retrieve the corpse during the Sabbath. When death occurs in an institutional setting, efforts should be made to permit the corpse to remain in the room until the Sabbath has ended. This will allow family members to ensure that the body is not left unattended.

If leaving the corpse in the room through the end of the Sabbath is not possible:

- One or two designees of the family should be permitted to accompany the body during transfer to the morgue.
- Once there, they should be allowed to sit in the room where the body is stored, or just outside.
- Staff should be aware that those accompanying the body will likely neither use the telephone nor turn lights on or off. They may also choose to take stairs rather than an elevator.
- In institutions where the morgue is in an area usually free from visitor traffic, security should be alerted that family members will be present.
- A chaplain should be contacted to provide emotional support and appropriate prayer books to those accompanying the body.

profoundly life-affirming. One woman describes her experience volunteering with the *ḥevra kadisha* as follows:

> I have never felt that combination of honor and terror as I did that very first time of performing the ritual. You never get used to that initial shock of walking into the room and finding a dead person on the table. Who wants to confront the evidence that we're going to die? After the first time I had trouble getting to sleep, but now, I can sleep. The honor always surmounts the terror of it. The purpose is to treat the body with utmost respect. I can't say that this experience changes me, but I do feel that I am in sacred space. It's really so loving, and a deep bond develops. After we perform *taharah*, I feel honored. We decompress. We share a bottle of Schnapps. We tell stories and go back to our regular life.

Arranging for Burial

In the biblical book of Genesis, God declares to the first humans, "You will return to the soil for from it you were taken. You are made from dust and to dust shall you return." Jews have traditionally interpreted this as a mandate for the body to be returned to earth following death with as little interference as possible. Any artificial impediment to decomposition is prohibited by Jewish law. Consequently, neither embalming nor the application of cosmetics to the deceased is traditionally permitted; in addition to hindering the decomposition process, they run contrary to the Jewish teaching that death should be confronted directly and recognized as the painful loss that is it.

> I wish to be cremated.
> One tenth of my ashes shall
> be given to my agent,
> as written in our contract.
>
> Groucho Marx

In Israel today, bodies are buried directly in the ground, wrapped in a shroud without a casket; this allows the body to decompose and "return to dust" as quickly as possible. However, American law in most localities requires the use of a casket; observant Jews usually select a plain pine box free from decoration. Holes are drilled into the bottom so that the corpse comes into direct contact with the earth. Further, every element of it should be biodegradable. For example, wooden pegs are often used instead of metal nails. Such a simple casket also reminds mourners of the utter equality human beings share in death, and no family need feel any embarrassment at not being able to afford a luxurious coffin.

Of course, many Jews today are uncomfortable with these ancient practices which can appear primitive or undignified to the modern observer. Also, some funeral homes may encourage a family to purchase a more expensive casket not ritually fit by traditional Jewish standards. Jewish tradition militates against such excess, teaching instead that a memorial fund or charitable donation which benefits people still living constitutes a much greater gesture to honor the deceased than a fancy coffin.

In a traditional burial, the body must be intact, meaning that even small amounts of fluid or tissue should be collected at the time of death and buried together with the body. Jews who believe in physical resurrection require this to ensure that the resurrected body is complete. Even Jews with alternate understandings of the afterlife typically value this tradition because it reflects the Jewish belief that the body is sacred, must be treated with great care and be returned to God whole. Observant Jews who have a limb amputated may even make arrangements for a funeral home to preserve and store the limb so that it can be buried with the person when he or she eventually dies.

Cremation

Some Jews today prefer cremation to a traditional Jewish burial. Arguments are made that it is more environmentally friendly and that it reduces the burden on mourners who may be spread across the globe and find it difficult to visit a gravesite far from where they live. Also, some people who choose cremation do so in part because they are terrified by the image of an unkempt and unvisited grave. For many people considering their death, cremation seems to offer more control over a frightening process.

Those Jews who choose cremation do so despite it not being permitted by Jewish law. The body is viewed as belonging to God: We borrow the body in life on the condition that we protect it as best as possible; after death, tradition says that we have no authority to alter it or destroy it in any way. Also, following the Holocaust where many Jews were cremated in acts of genocide, the practice became offensive to many Jews, even some who do not normally hold by strict Jewish law. In most Orthodox communities, a person who was cremated is not mourned formally: There are no funeral rites or other mourning rituals such as *shiva* or the recitation of *kaddish*. Many non-Orthodox rabbis will argue strongly for traditional burial before the decision is made but, after a cremation, will agree to officiate at a funeral or memorial service and perform other rituals intended to honor the deceased and comfort the mourners.

Family members often face a painful dilemma when they wish to honor their loved one through normative Jewish practices but also wish to respect the deceased's request to be cremated. Jewish law generally inclines towards what will bring the most comfort to the bereaved. Different rabbis propose various solutions to this conflict. Despite a rabbi's counsel, however, this choice can lead to arguments and increased family tensions while mourners are in an especially raw emotional state.

Rending of Garments

> Jacob rent his clothes, put sackcloth on his loins and mourned for his son many days.
>
> **Genesis 37:34**

Immediately prior to a traditional funeral service, a rabbi meets with the family privately. If they did not do so when they first were informed of the death, family members perform the ritual of *keriah*—ripping—at this time, rending a garment to symbolize the brokenness they feel. Traditionally, men tear the lapel of a jacket or a tie, while women tear their sweater, blouse or scarf. In so doing, mourners mutilate something valuable which they cherish and have now lost forever. Many Jews today prefer to tear a symbolic black ribbon, often provided by the funeral home, pinned over the heart following the death of a parent and over the right breast for others. Mourners traditionally wear the rent garment or ribbon throughout the entire *shiva* period—the seven days following burial.

The Jewish Funeral

Because Jewish funerals take place so quickly following death, the atmosphere is often one of shock or intense anguish. Traditional Jewish funerals are strikingly stark: the casket is closed and covered with a simple cloth unadorned by floral arrangements; Jewish tradition encourages mourners to remember the person as a vibrant living human being instead of a corpse. There is no music, honor guard or display of colors to blunt the painful reality that a death has occurred.

The funeral liturgy is quite simple, consisting of several Psalms followed by eulogies. The Hebrew word for eulogy—*hesped*— implies lamenting; the eulogies are a time to reflect on the life of the deceased and lament the qualities that are lost. Jewish tradition prohibits exaggeration and saintly portrayals with little basis in reality. Following the eulogy, a memorial prayer called *El Maleh Raḥamim*—God, Full of Compassion—is chanted by the rabbi or service leader. At the conclusion of the service, pallbearers are called forward to carry the coffin to the hearse, followed by the immediate family, the rabbi, and, finally, the guests. Serving as a pallbearer represents an honor usually reserved for direct descendents of the deceased or other close family.

Once the casket is lowered into the ground, the rabbi declares in Hebrew, "May [the person's name] go to his/her place in peace," and then hands a shovel to the principal mourner, usually the spouse or child of the deceased. He or she uses the back of the shovel to lift the first load of dirt into the grave, symbolizing the mourner's reluctance to complete the task. The sound of the first shovelful of rocks and dirt falling onto the wooden coffin often elicits tears or shrieks from those in attendance.

After the first inverted shovelful, the shovel may be used regularly. Those present gather in line for their turn to help fill the grave. Some individuals only lift a symbolic amount of dirt into the grave; others shovel furiously. The grave need not be filled to completion, but enough that the coffin is entirely covered before proceeding.

Once this process is complete, the mourners recite the most well-known graveside prayer, the *kaddish*. As discussed in the next chapter, this prayer affirms God's greatness at a moment when the mourner may feel most distant from or angry with God. It accepts the painful reality of the present but also provides hope that redemption arrive soon. The graveside reading marks the immediate family's first recitation of the *kaddish*. They may continue to recite it daily from this point on, for up to a year.

After the recitation of the *kaddish*, all in attendance except the immediate family of the deceased arrange themselves into two lines. The immediate family then leaves the graveside, passing through these rows of comforters; they are reminded that they are not alone in their grief but surrounded by a supportive community. As the family members pass, individuals offer the traditional consolation:

> *Ha-makom yinaḥem et-hem b'tokh sha'ar avelei tzion v'yerushalayim.* (May the Holy One comfort you together with all the mourners of Zion and Jerusalem.)

Upon leaving the cemetery, a bucket of water may be provided with a small cup just outside the gate. It is customary for all mourners to use the cup to scoop water over their hands. This ritual hand washing symbolizes that attendees of the funeral do not carry any impurity with them following their contact with the dead. This ritual also marks the moment when the focus shifts from honoring the dead to comforting the mourners. Until now, the mourners' sole responsibility was to ensure that the burial proceeded

Assistance with Providing a Traditional Funeral

Local Jewish funeral homes around the country can assist families in finding resources to help them pay for an appropriate Jewish funeral if they cannot afford one on their own.

in a way that bestowed the highest honor possible on the deceased. Now their attention turns to their own grief, and the attention of the community turns to supporting the mourners.

For more regarding Jewish burial customs, funeral rites and mourning practices, see *Saying Kaddish: How to Comfort the Dying, Bury the Dead and Mourn as a Jew*, by Anita Diamant, Schocken Books, 1999.

Rituals for Specific Circumstances

Suicide

Jewish tradition holds that the body belongs to God, not the person who inhabits it. Consequently, suicide has been viewed in classical Jewish tradition as a direct rejection of divine authority. During the course of Jewish history, the family of a suicide was not permitted to rend their garments and eulogies were not offered at the funeral. Many Jews today know of the customary practice of burying suicides at the far corner of cemetery grounds.

As Jewish authorities began to better understand mental illness, and suicide in particular, during the twentieth century, these restrictions have been relaxed in almost all situations. One who kills himself or herself while suffering from mental illness now need not be excluded from the community after death. Even when no formal diagnosis of mental illness is present, Jewish tradition has come to understand that almost all suicides suffer from duress, despair or other mental anguish which may have been hidden to others. Judaism now views a suicide as a lost opportunity to share in the blessings of life, but not as a sin to be punished. *Today, the rituals of mourning do not differ following a suicide.*

Perinatal Loss and Infant Death

The central Jewish mystical text, the *Zohar*, offers a lament on behalf of infants who die:

> Most hideous is the pain of the oppressed ones who are taken from their mother's breast while still suckling. The whole world weeps on their behalf. Nothing compares with the tears that flow from these babies; they issue from furthest and darkest places of the heart. The entire world stands confused exclaiming: Just are the judgments of the Holy One, blessed be He, and God's ways are the ways of truth. However, it is necessary that these sad infants, without sin and without guilt, should die? Where is the just and righteous judgment from the Ruler of the World?!

Because perinatal loss and the death of infants was so common in the ancient world, the mourning customs developed for these situations are not necessarily appropriate for modern times where this kind of loss is so much more rare.

Customarily, one did not hold a standard funeral, recite *kaddish* or sit *shiva* (a period of mourning in the home; see Chapter VI) for a baby who died during the first thirty days of life. This tradition was instituted to ease the

Appropriate Conduct at a Jewish Funeral—A Guide for Non-Jews

Nowadays, a Jewish funeral is typically divided into two parts: the service, which usually takes place at the funeral home or a synagogue, and the interment. Sometimes, both elements are combined at the graveside, as they were in pre-modern times.

Those who have not attended a Jewish funeral previously should familiarize themselves with the following points. However, it should be emphasized that the simple act of attending the funeral is sign of great honor and respect for the dead. There is no unintentional *faux-pas* or good-faith ritual mistake which would show dishonor to deceased or the family.

- Proper attire consists of a jacket and tie for men and modest dress for women.
- Flowers should not be offered or delivered. They are traditionally viewed as a vain effort to hide the pain of the loss. Instead, a donation should be offered in memory of the deceased to a charity that represents the values of the deceased.
- Guests should plan to arrive early as funeral services start promptly.
- All men, including non-Jews, should cover their heads out of respect, both inside the chapel and at the graveside. An appropriate hat may be worn or guests may borrow one of the skullcaps offered by the funeral director.
- Though it is common to see old friends, acquaintances and colleagues, a Jewish funeral is not an appropriate time for casual conversation. Whatever is said should be spoken softly.
- Guests should not greet family members in mourning. Even when the intent is to offer comfort, the appropriate time and place is at the *shiva* house, not prior to the service.
- Guests are invited to respond "Amen" at the conclusion of all prayers offered during the service, and to participate in any English responsive readings.
- Following burial, guests should feel encouraged to shovel dirt into the grave. Jewish tradition views filling the grave as a final act of kindness which those in attendance may offer to the deceased.
- Little should be said to the family members at the graveside after interment. Even well-intended kind words serve to distract the mourners from their own grief. The traditional Hebrew prayer offered to the mourners at this time is brief: "May the Holy One comfort you together with all the mourners of Zion and Jerusalem."

burden on parents in ancient times when infant mortality was high. Families who may have lost several children would be greatly encumbered by complete observance of all mourning practices. Today, many rabbis suggest that parents observe these rituals even though traditionally they are not required to. In such situations, often the *shiva* period is three days instead of seven.

How to appropriately mourn a stillbirth or miscarriage remains an active area of discussion in many Jewish circles. Grieving parents should be referred to a Jewish chaplain or rabbi who will guide them through the rituals specific to their situation. Generally, if the loss occurred in the fifth gestational month or later, burial of the remains is required by Jewish law, usually without a marker or formal graveside service. Most Jewish cemeteries have a section reserved for this purpose. Some rabbis assert the need for a circumcision following the stillbirth of a male child, and a naming ceremony for any stillborn child, so that no Jewish life remains anonymous. Even rabbis who do not believe these rituals are required may nonetheless suggest them if it seems they might help ease the parents' pain. *Shiva* is not usually observed following the burial of a fetus, though the community may elect to observe a *Yom Niḥum*—day of comfort—where guests offer blessings, prayer and support to the parents. The mother may enter the *mikvah*—ritual bath—following her physical recovery as an act of spiritual healing, affirming her wholeness and holiness.

For more on ritual ceremonies following pregnancy loss, see www.ritualwell.org/lifecyclespregnancyinfertility and *Tears of Sorrow, Seeds of Hope: A Jewish Spiritual Companion for Pregnancy Loss and Infertility* by Rabbi Nina Beth Cardin, Jewish Lights Publishing, 2007.

VI. Elements of the Mourning Process

This chapter discusses the various parts of the traditional Jewish mourning process. The process has several formal stages, including an intense period of mourning for the first week after the burial, followed by a transition period of another thirty days during which continued mourning begins to combine with daily life. For the children of the deceased, formal mourning practices continue for another eleven months. At the end of a year, a certain closure is brought to the process by the marking of the anniversary of the death. In subsequent years, the memory of the deceased may be celebrated in a number of ways.

Beginning the Mourning Process

Jewish beliefs and customs commonly observed during the first month following a death including *shiva*, mourning in the home during the first week. This is followed by a less intense mourning period of thirty days, called *shloshim*. Throughout this period, Jewish tradition calls for mourners—by custom, this means a spouse, parents, children and siblings—daily to recite specific prayers and refrain from some activities.

> [Jewish law] commands the mourner
> to undertake an heroic task:
> to start picking up the debris
> of his own shattered personality
> and to reestablish himself as a man,
> restoring lost glory, dignity
> and uniqueness...
> No matter how powerful death is...
> however terrifying the grave is...
> no matter how black the despair is...
> we declare and profess...
> that we are not giving up...
> that we will carry on the work of our
> ancestors.
>
> Rabbi Joseph B. Soloveitchik,
> 20th Century Scholar

The House of Mourning—*Shiva*

Maybe the most well-known Jewish mourning practice is *shiva*—a seven-day period of focused mourning, prayer and consolation. The term derives from the Hebrew word for seven because it traditionally extends through the first seven days following burial. It also sounds like a form of the Hebrew verb "to sit" which calls to mind one of *shiva*'s most salient customs: mourners sit on low stools or overturned crates, symbolizing their sorrow and discomfort. In English, people often refer to mourners as "sitting *shiva*."

Shiva is traditionally observed in the home of the deceased or of the primary mourner, usually the spouse or an adult child of the deceased. However, in today's society, with families often spread apart, *shiva* may be observed simultaneously by different mourners in separate locations, or by the same mourners in more than one place over the course of the seven days.

Shiva begins as soon as the mourners return home from the burial, when they turn from honoring the deceased to expressing their own grief. Upon arriving home, traditional mourners may remove their leather shoes, which symbolize luxury, and refrain from wearing them throughout the seven days. They also light a large memorial candle—*ner daluk*—which burns throughout *shiva*, offering a concrete symbol of hope in a setting filled with emotional darkness. Customarily, the doors of a *shiva* house are not locked in order to encourage visitors. Mourners are not generally left alone during *shiva*, though all requests by the family for privacy and respite are to be respected.

There is no right or wrong way for mourners to behave during *shiva*. Some may prefer to sit in silence with their pain; others may prefer to talk about their loss. It is common during *shiva* for mourners to cry, reminisce, leaf through photo albums and swap stories about the deceased. Often a mourner is able to express grief directly at times, but needs silence at others.

For some, *shiva* proves to be a period of increased family tension. Estranged siblings may share tight quarters and interact with each other more than they have in years. Different levels of religious observance among mourners may lead to disagreements about appropriate behavior or ritual practice. Regression to childhood coping mechanisms and family dynamics is common. However, sometimes the direct conflict which bubbles up during mourning, while painful, is the first step towards resolution of longstanding family tensions.

Shiva is not observed over the Sabbath—Friday sundown through Saturday sundown. Mourners are encouraged to leave their home and enter the synagogue to celebrate the Sabbath even in the midst of their grief. Some other Jewish holidays also interrupt *shiva*, delay its start or cause it to end early, depending on when the holiday falls in relation to the death. Though *shiva* technically extends for seven days, the day of the funeral is counted as one full day and *shiva* ends just after morning prayers on the last day. This means that, in most cases, mourners spend only about four full days actually "sitting *shiva*." In modern practice, some

Jews shorten this period even further, most commonly to three days.

The community is obligated to offer comfort and support. Jewish law forbids mourners from eating any food they have prepared for themselves on the day of the burial. This forces friends and others to come to the home in person, sustaining the mourners physically with gifts of food and emotionally with their presence. The religious obligation to visit a *shiva* house falls on the entire community; there is no expectation that a visitor had known the deceased well, or even at all. Mourners are known to experience profound comfort from condolences and support by community members who were virtual strangers to them. A sense of the emotional and physical support generated by the practice of *shiva* can be gleaned from a woman's description of her experience:

> When I sat *shiva*, about fifty people would pass through my house every day. They would bring food and speak with each other. I had this incredible realization that all of these people cared about me and I could call on them anytime I wanted to. They would be there in a heartbeat. My sense of feeling alone was completely delusional. Actually, I was surrounded. The most amazing thing for me was that all these people were there because they cared about us and there was no way I could fall. They were there in my dark hour.

> Why are lentils proper food
> for mourners? As the lentil rolls,
> so does the mourning roll
> from one person to the next.
> As the lentil is silent
> (without a cleft opening),
> so too is the mourner silent.
>
> — THE TALMUD

The first meal in a *shiva* house is called a *se'udat havra'ah*—meal of condolence. It usually begins with a blessing over the bread, a simple act of offering gratitude for what one has at a time when mourners are normally focused on what they have lost. The menu traditionally includes round foods such as lentils and eggs, symbolizing the cycle of life. Often, guests serve the mourners before partaking themselves.

Jewish law prohibits mourners from attending work or school during *shiva*. It is a time to begin processing one's grief and acknowledging the loss—an immediate return

How to Pay a *Shiva* Call—A Guide for Non-Jews

The etiquette for visiting someone sitting *shiva* is quite different from visiting the same person at home on another occasion. Some behaviors which are generally considered "good manners" for a social visit may prove burdensome for mourners and interfere with the grieving process. The following are some basic guidelines for a standard *shiva* visit.

- Check to see if the mourners have suggested specific hours for visiting. Families often do this to allow the principal mourners to rest and spend quality time with each other.
- Outside the house, you may find a bucket of water. The custom is to ritually wash one's hands before entering, marking the transition between the world of the mourners and the world outside.
- The door is likely to be unlocked. If so, let yourself in quietly. Knocking or ringing the bell may interrupt a prayer service or a mourner's conversation.
- Flowers are inappropriate in a *shiva* house. The best gift is food, though visiting without a gift is both common and acceptable. If you do plan to bring food, make sure that it is certified kosher or at least strictly vegetarian—even if the family does not observe Jewish dietary restrictions, other visitors may.
- The custom among observant Jews is not to speak to a mourner until he or she has addressed you first. If the mourner does not acknowledge you upon entry, sit quietly. In less traditional settings, visitors may initiate conversation with the mourner by offering brief words of condolence.
- Mourners traditionally do not greet visitors with a standard "hello" or "how are you?" during *shiva*. If this is the case, understand that it represents a longstanding Jewish practice, not rudeness.
- There is no "right" thing to say and there are very few wrong things to say. Visitors provide comfort merely by being present. However, it is inappropriate to attempt to cheer up the mourners, advise them about how to mourn or seek to take their mind off of their grief.
- The primary task of the visitor is to listen, not speak. Let the mourner direct the conversation. If he or she wants to talk about the deceased, ask open-ended questions which allow the mourner to relate stories. Good questions include: What kind of obstacles did he overcome in life? What things were most important to her? What was he like as a father/husband/brother? What were her final days like? You may also share a story of your own about the deceased. Try to avoid asking, "How are you doing?" Such questions tend to elicit one-word answers, stifling more substantive conversation.
- Mourners may ask you about your well-being, family or job. It is appropriate to answer briefly, but do not speak about yourself at length. The focus should always be on the deceased and those left behind.
- Visitors are likely to see people they know in a *shiva* house, some they may not have spoken to in a long time. A *shiva* house should not become a place for casual conversation, though it often does. A simple greeting of other visitors is appropriate, but if another visitor attempts to engage you in conversation unrelated to the deceased, suggest making a plan to meet or speak on the phone later.
- A good *shiva* visit need not last more than about twenty minutes. Grieving can be very tiring for the mourners. Be sensitive to clues the mourner may be sending requesting that you end your condolence conversation with them.

to standard routines might falsely appear to diminish the death's impact on the mourner. Jewish law does, however, permit certain leniencies when the financial burden of lost work would cause the mourners significant hardship.

The mourner physically represents his or her incompleteness during this time by not focusing on outward appearance. To this end, many people observe the custom of covering all the mirrors in a *shiva* house as a rejection of vanity during this period. Traditional mourners may also refrain from most acts of personal grooming, such as shaving or applying makeup.

Jewish law forbids most pleasurable and other non-essential activities during *shiva,* such as sex, games, shopping and even Torah study. Judaism's incorporation of this self-denying behavior into traditional mourning practices validates the human tendency to self-punish; simultaneously, it strictly prescribes its boundaries, lest it expand into a complete disregard for one's own welfare.

The *Kaddish*

(a translation from the Hebrew)

Magnified and sanctified
is God's great name throughout the world
which God created.
Speedily may God's kingship reign
for all our days, during our lifetime and
the lifetimes of all the people of Israel.
Let us say: Amen.

May God's great name be blessed
throughout eternity.

Blessed, honored, glorified, exalted,
extolled, decorated, lauded and praised
is God's holy name beyond all blessing,
song and tribute that we may ever offer.
Let us say: Amen.

May great peace descend from the
heavens along with full life upon us and
upon all Israel. Let us say: Amen.

May the One who makes peace in the
universe grant peace to us and to all
Israel. Let us say: Amen.

Prayer During Mourning—Kaddish

Jewish law obligates most mourners to recite the *kaddish* prayer three times daily for a month following burial. Children of the deceased recite it for an entire year. In Orthodoxy, the prayer is only required of men; in more liberal movements, the obligation falls on both men and women. The *kaddish* prayer may only be said in a *minyan*—a group of ten Jews (in Orthodoxy, ten men). This requirement forces mourners to remain connected to their community and not shrink into isolation during their grief. Because it is customary for mourners not to leave their home during *shiva,* a traditional community arranges for a *minyan* to be present in the *shiva* house three times a day so that the prayer may be said. Once *shiva* has ended, *kaddish* is recited in the synagogue.

The *kaddish* prayer offers praise and pronounces that God will speedily bring peace to the entire world. There is no mention of death or mourning. It is a prayer whose text looks forward to a better time even as the reader hearkens back on what has been lost. The prayer asserts God's love and compassion at a time when the mourner feels it is most absent. It affirms that death and loss comprise essential elements of the divine plan for ultimate redemption.

In a traditional synagogue, the congregation remains seated while the mourners rise to recite *kaddish,* the mourners thereby publicly announcing their loss. As those saying *kaddish* read together, the congregation responds, "May God's great name be blessed throughout eternity." The community declares through this ritual that the mourners do not stand alone in their grief. The strength and words of the group encourage the mourner to bless life instead of surrendering to death.

For personal stories of experiences during the first year of mourning, see *Kaddish,* by Leon Wieseltier, Vintage, 2000, and *Living a Year of Kaddish: A Memoir,* by Ari Goldman, Schocken Books, 2006.

Mourning Non-Jewish Family Members

While Jewish tradition has generally placed great emphasis on endogamy, many Jews in America today have non-Jewish spouses, relatives or close friends. This phenomenon is accelerated by rates of conversion to Judaism which

have increased greatly in recent years. These Jews face complicated questions when it comes to deciding how to mourn their non-Jewish family members and dear friends.

According to strict Jewish law, there is no formal obligation to recite *kaddish*, sit *shiva* or observe other customary mourning rituals for non-Jews. However, Jewish mourning rites are designed to console those left behind, so most non-Orthodox rabbis encourage Jews to observe these customs if they might bring comfort to the mourner.

Many rabbis decline to officiate at the funeral of a non-Jewish relative, though some may be willing to offer a eulogy. Traditional Jewish cemeteries will not bury non-Jews next to Jewish spouses or relatives; however, some provide a separate area just outside the grounds so that intermarried couples may be buried together.

The deceased may have had a strong affiliation with another faith tradition, which dictates a non-Jewish burial and funeral. If so, Jewish mourners may feel alienated by not being able to honor their loved one with basic Jewish rites such as a speedy burial and accompanying the body from the moment of death onward. Jewish mourners may want to sit *shiva* but find that the process isolates them from their non-Jewish family members who mourn in other ways. Because converts may be especially eager to observe death in "the proper Jewish way," the guilt of not doing so can become burdensome, making an already complicated emotional period all the more difficult. The introduction of a chaplain or experienced rabbi can often help to resolve such a crisis, comforting mourners and helping them adapt traditional customs to meet the needs of specific situations.

> Rabbi Levi says: A mourner during the first three days [of *shiva*] should see himself as if a sword lies on him between his two thighs; from the third to the seventh day it is as if it faces him in a corner; afterwards it is as if it moves along with him in the market.
>
> THE TALMUD

The First Month Following Burial—*Shloshim*

Shiva concludes just after completion of the morning prayers on the seventh day. Though there is no formal ritual to end *shiva*, often families take a walk outside, to get fresh air and to symbolize the beginning of their gradual reentry into the world. The religious restrictions on the mourners' behavior during *shiva* are now relaxed: mirrors are uncovered; laundry is washed; low stools are replaced by standard chairs. Daily life is allowed slowly to reassert itself.

This transition can be painful and often marks the time when mourners are most vulnerable. Comforters no longer visit. Condolence calls grow fewer and fewer. Other people return to their normal lives and the mourners receive the implicit—and sometimes explicit—message that they are expected to do so as well.

Jewish tradition recognizes this vulnerability by establishing a transitional period called *shloshim*—thirty days. Following the completion of *shiva*, observant mourners may return to work and reestablish old routines, but they continue to refrain from sexual activity, public celebrations and acts of self-care such as wearing new clothes or shaving, during the remainder of first month following the burial. Mourners reenter the community through synagogue attendance, work and family obligations, but simultaneously they remain apart. These continuing restrictions mirror the mourners' emotional alienation, encouraging them to confront it.

Different Rituals among Sephardic Jews

The majority of Jews in North America are known as *Ashkenazi* Jews, which means they trace their family roots through Central or Eastern Europe where, historically, they lived among Christians. However, about 3 percent of Jews living in North America, and a much larger percentage of Jews worldwide, descend from families that once lived in North Africa, Asia Minor, the Levant, Arabia, Persia or Muslim-controlled sections of the Iberian Peninsula. These Jews are commonly called *Sephardi* or *Mizraḥi* Jews and historically were surrounded by Muslim culture. While both communities share most core Jewish practices and values, each also holds unique customs and traditions.

This book, including this chapter on burial, funeral and mourning practices, focuses on Ashkenazi tradition. Care providers should be aware, however, that Sephardic Jews may have practices quite different from those discussed here. For example, in some Sephardic communities, sons attend the burial of their mother but not of their father. Women from the Sephardic tradition may engage in ritualized weeping and wailing at the funeral or graveside. At the cemetery, some Sephardic males circle the funeral bier seven times, publicly seek forgiveness from the deceased, and blow a *shofar* (ram's horn) following the burial. In some Syrian Jewish communities, men and women are buried in separate sections of the cemetery, in the next available grave. In Persian Jewish communities, rosewater is often sprinkled on the grave.

While Ashkenazi Jews traditionally sit on low stools during *shiva*, Sephardic Jews are more likely to sit on pillows placed directly on the floor. Often there is a formal ceremony among Sephardic Jews to end the period of *shiva*, which involves the reading of sacred texts, additional eulogies and guests offering sweets to the mourners. The Yiddish term *Yahrzeit*, referring to the anniversary of the death, is called *Mishmarah* or *Naḥala* by Sephardic Jews and may be commemorated with the reading of Psalms together with the lighting of a candle.

There is no formal ritual to end *shloshim*, though often families gather for a prayer service or study session in honor of the deceased. Families spread across great distances may reunite for the thirtieth day, to offer each other support and share their experiences of the past month.

> Whoever sees a mourner within thirty days should comfort him but not ask him how he is feeling. After thirty days, within the first year, he should ask how he is and then comfort him.
>
> THE TALMUD

Clinicians who treated the patient and worked with the family prior to death are strongly encouraged to use this time to follow up with mourners. In situations where there is no ongoing professional relationship with the family following a death, a brief phone call around the thirtieth day may provide tremendous support. This shows respect for the family's loved one by the physician.

The Continuing Mourning Process

Jewish bereavement practices do not end with the close of *Shloshim*, the transitional month following the burial. They continue for the children of the deceased for the next eleven months, culminating in a commemoration on the anniversary of a death. There are also ritual commemorations of the dead on certain Jewish holidays throughout each year.

Bereavement During the First Year

Death challenges a person's belief in the safety, predictability and fairness of the universe. The critical task of healing is to make sense of the loss and eventually rebuild a worldview in which life has meaning despite its fragility and the surrounding chaos. Jewish tradition does not expect individuals to engage in this difficult work alone. While the obligation to recite *kaddish* ends after thirty days for some mourners, children mourning their parents continue for eleven more months. Those observing this custom find themselves creating a supportive community with others who similarly attend synagogue every day in order to recite the prayer.

For help finding local healing services, contact The National Center for Jewish Healing at www.ncjh.org or by phone at (212) 399-2320. Bereavement groups for Jewish mourners of all religious orientations can be located through the directory on the website of The Association of Jewish Family and Children's Agencies at www.ajfca.org or by phone at (800) 634-7346.

Some Jewish mourners find comfort in the healing services which have become increasingly popular in non-Orthodox synagogues. Often scheduled on a weekday evening, healing services do not follow a rigid format but generally provide space for meditation, prayer, song and companionship. Attendees may reflect on the changes that illness, divorce, death or other types of loss have introduced to their lives. They find comfort surrounded by others in various stages of coping with their own losses.

Bereavement groups may also offer comfort and companionship, bringing together different people with shared experiences. Mourners who might otherwise incline towards isolation form new relationships and often develop intimate bonds with others. Even when someone has a solid support network of friends and family, the experience of sharing coping strategies and offering support to others who are also suffering can prove incredibly beneficial. Bereavement groups are offered by many synagogues, funeral homes, hospices, long-term care facilities and a growing number of acute care hospitals.

Unveiling the Headstone and Visiting the Grave

Tombstones in a Jewish cemetery are usually simple, engraved with the name and date both in Hebrew and English. Often they also include a series of Hebrew letters, shorthand for the phrase, "May his/her soul be bound up in the bonds of life." Traditionally, Jewish gravestones were placed with little ceremony. However, in recent times, many American Jews have adopted the practice of "unveiling"—holding a brief graveside service within a year of the death, sometimes on the first anniversary. The service is usually attended only by close friends and family. The rabbi, cantor or lay leader will offer brief Psalms and prayers. Those present may share stories or other memories. Sometimes the stone will be covered with a simple cloth during the service and then officially "unveiled" for the first time at its conclusion.

Mourners are discouraged from visiting the grave too often, and Jewish law specifically forbids visits on festive occasions such as the Sabbath or other major holidays. However, it is a widespread custom for loved ones to visit on the anniversary of the death, prior to the High Holidays (in autumn) and before major celebrations such as weddings or bar/bat mitzvahs. Mourners may also visit on dates of personal significance such as birthdays and wedding anniversaries as well as anytime they feel the need. Bringing flowers to the grave is considered an echo

of ancient pagan traditions and is thus prohibited under strict Jewish law.

Following a visit, it is customary for each person to place a small stone or pebble on top of the gravestone. Scholars claim that this custom may date to biblical times when tombs were marked by a makeshift pile of stones. Mourners would add to the pile, symbolically expressing their love for the deceased and their desire to care for him or her eternally. A gravestone with pebbles resting atop testifies that visitors have come, remembering their loved one.

The First and Subsequent Anniversaries—*Yahrtzeit*

Yahrtzeit is the Yiddish word for "the time of the year" and refers to the anniversary of a death—traditionally marked on the lunar Hebrew calendar. The first *yahrtzeit* often presents conflicting emotions. Some memories which have begun to fade are likely to reappear. For several weeks before, mourners may think back on what they were doing at that time one year previous—driving to the hospital, speaking to the doctor, sleeping on the chair in the waiting area, even the moment of death itself. People who have been reciting *kaddish* regularly will also be preparing for the end of this supportive ritual. On the day itself, emotions from the early stages of grief may return. At the same, the first *yahrtzeit* can also bring relief and a sense of accomplishment.

The formal commemoration of a *yahrtzeit* is minimal. The observant mourner attends synagogue to recite *kaddish*, the name of the deceased is announced publicly during the worship service and a 24-hour candle is lit in the home. Many modern synagogues have plaques on the wall to honor deceased members; these are illuminated on the day of the individual's *yahrtzeit*. Some mourners add to these basic rituals by gathering family and friends together, sharing meals and telling stories.

Memorial Services and Other Ways to Remember

Following the slaughter of Jews during the Crusades, rabbis introduced a prayer service known as *yizkor*—memorial—to honor the martyrs. Over time, it grew to include memorial prayers for all who have died. Today this service is included in the liturgy of four major Jewish holidays: *Yom Kippur* (Day of Atonement), *Pesach* (Passover), *Sukkot* (Tabernacles) and *Shavuot* (Weeks).

A typical *yizkor* service lasts no more than twenty minutes, though it runs adjacent to the much longer morning prayers of the holiday on which it falls. Sometimes, a member of the congregation or the rabbi will introduce the service by sharing a few words about his or her own experience of loss. The liturgy begins with Psalms and often some responsive readings in English. Some synagogues have the custom of reading the names aloud of all who died in the past year, or in recent memory.

The congregation is then offered time to reflect and pray silently. Prayer books include several different paragraphs to read in silence, specific to the mourner's relationship to the deceased. In addition to prayers for a lost parent, sibling, spouse or child, one may also silently recite prayers for victims of the Holocaust who have no descendants to pray on their behalf. The prayer leader breaks the silence by chanting the memorial prayer *El Maleh Raḥamim* (God, Full of Compassion), then the entire congregation recites the *kaddish* in unison.

Some people do not attend the *yizkor* service during the first year after a death, waiting instead until the initial *yahrtzeit* has passed. While observant Jews attend all four *yizkor* services a year, many less traditional Jews place primary emphasis on the *yizkor* service during *Yom Kippur*. In the home, many people light a memorial candle on the days that *yizkor* is said.

It is typical for mourners to donate money to *tzeddakah*—charity—in memory of the deceased. Mourners continue to give on a regular basis, timed to the anniversary of the death, a birthday or other personally significant dates. Jewish tradition values the giving of time and effort over money, however, so many mourners may prefer to volunteer directly. Other mourners may engage in a process of Torah study to honor the deceased. Or one might enroll in an adult education class, sponsor an informal study group or simply read about any meaningful religious topic.

Naming the next-born child in honor of a deceased relative has also become an important custom among Jews from Eastern Europe. At the baby's circumcision or public naming ceremony, often the parents explain the name choice and emphasize the values of the deceased which they hope the baby will embody. Sometimes the entire name is given; other times parents select a name beginning with the same first letter.

VII. Epilogue—Final Thoughts

It's been 24 years since my son Gregory died. He was 20 years old. What I've done every year is to go where he is buried. It's lovely there; we all go down to visit the gravesite. There are always about 15 people who go—people who knew him. We tell stories, sometimes we cry. I still put a candle in a shallow bowl of water, fill the rest with flowers, get his picture, set it out and light my candle. It's the picture I took the last time I saw him at a café. I don't have any pictures of him as an adult, as adult as he got to be. Someone always reads *kaddish* with me. It's tremendously comforting, deliberately comforting so the mourners will not be alone. Then we go to a friend's house, she makes sandwiches and we eat.

I did this for 20 years on his *yarzheit* day. It's become hard for me to travel there on that day, but his friends still go. I go a little later on.

The first year, I was a wreck. It was like recovering from surgery: I was exhausted, had no energy, and it took a long time for me not to feel devastated. The first *yarzheit*, it was like I had to go through the death again. For two to three months leading up to it, I got nervous, agitated. It was such a profound experience. It was like he was going to die again.

The second year was similar, but not nearly as strong. And then the third year. Every year, on his *yarzheit*, I would say, "Yes, I feel better." Then about three days after the fourth *yarzheit*, it was dramatic. I woke up and said, "I am really finally myself again." And that was true. It took that long for me to feel like I had truly recovered. The thing is, all along, I didn't know I was recovering. After the fourth *yarzheit*, it was like coming back without the veil. I was myself again.

This testimony of mourning illuminates Judaism's emphasis on communal support and involvement. Many of the rituals and teachings discussed in this guide have the effect of bringing people together, overcoming the isolation that so often accompanies illness and loss. Appropriate care for the Jewish person, then, considers and involves family, friends and the broader community.

Jewish thought also rejects sharp distinctions between physical and emotional suffering, viewing the body and soul as profoundly interconnected. Appropriate care therefore also addresses not only a patient's immediate physical distress but also his or her underlying emotional experience. Jewish tradition values the relief of suffering, struggles to maintain hope even in grim situations, and challenges Jews to look for opportunities for spiritual and personal growth through difficult experiences.

Once a death has occurred, Jewish tradition immediately directs its attention towards showing respect for the deceased. This takes its most concrete form in elaborate Jewish rituals surrounding care for the corpse. After burial, comforting the mourners becomes the focus, and is the responsibility of the entire community. That comfort may at times be provided in the form of logistical support or other direct assistance but, at its core, comes through listening, presence and empathy.

Judaism views mourning as part of a year-long cycle. Throughout that cycle there are moments for healing, growth and acceptance. There is also license for intense emotion—anger, fear, sadness, isolation, grief. While this guide details the most common traditional bereavement practices in Judaism, many individuals observe them in modified forms or observe some strictly while abandoning others. This guide tries to make clear to its readers that the wide variety of experience and expression of contemporary Jewishness makes it impossible to accurately predict how any one Jewish patient or family member will respond to illness and death. Instead, the guide is intended to introduce clinicians and other caregivers to the complicated cultural and religious framework through which many contemporary Jews view sickness, loss and emotional healing.

No Jewish patient or family member expects caregivers to fully understand all the relevant cultural and religious factors relating to these issues. But this guide may at least enable readers to better appreciate the broader cultural and spiritual dynamics at work in any given situation, and empower him or her to ask the questions that can help create sufficient space for the perspectives, beliefs and practices of all those involved.

Glossary of Hebrew and Yiddish Terms

The following Hebrew and Yiddish terms are found throughout this guide. The pronunciation guide for Hebrew words within this glossary follows contemporary Israeli usage. Many American Jews, however, employ alternate pronunciations, heavily influenced by Yiddish, which stress different syllables, shorten vowels and alter some consonant sounds.

A dot under the letter "h" represents a guttural sound, similar to the "ch" of the Scots/English word *loch*.

Aninut (ah-nee-*newt*)—the period of time between death and burial; during this time, mourners are exempt from all religious obligations unrelated to preparations for burial.

Ashkenazi Jews—Jews who trace their roots through Central and Eastern Europe.

Bar Mitzvah (male)/**Bat Mitzvah** (female)—the ceremony conferring status on a 13-year old as full member of the community for ritual purposes.

Bikkur Ḥolim (*Bee*-kur ḥo-*leem*)—the Jewish obligation to provide care and support for those affected by illness.

El Maleh Raḥamim (Ale Maleh Rah-kḥah-*meem*)—literally, "God, full of compassion"—a prayer in honor of the dead, often chanted at funerals and other memorial services.

Goses (Go-*say*-s)—an actively dying person with no hope for physical recovery.

Ḥesed (*Ḥeh*-sed)—loving kindness.

Ḥesped (Ḥess-payd)—a eulogy.

Ḥevra Kadisha (Ḥev-ra Ka-*deesh*-ah)—literally, "a holy society"—the group of Jewish volunteers who wash and prepare the body for a traditional burial.

Kaddish (Kah-*deesh*)—a prayer recited by mourners following a death.

Keriah (keh-*ri*-ah)—literally, ripping, the custom of mourners to tear a piece of clothing or a ribbon after a death.

Kevod Ha-met—the obligation to show honor and respect for the corpse prior to burial.

Kippah (Key-*pah*)—the head-covering worn by Jewish men; *Yarmulke* in Yiddish.

Kittel—the while linen robe worn on certain holidays and for a traditional burial.

Levayah (Leh-vai-*yah*)—literally, accompanying—a Jewish funeral.

Matzevah (Mah-*tzei*-vah)—a tombstone or grave marker.

Mikvah—a ritual bath of natural flowing water, used for purification rituals including the submersion of a corpse prior to burial.

Minyan—a prayer quorum of ten, required for certain prayers such as the *kaddish*.

Mi-shberakḥ (*Mee*-sheh-bay-raḥ)—a prayer recited on behalf of someone who is ill.

Mitzvah—a religious obligation; also used by some to describe a good deed.

Ner Daluk (Nair Dah-*louk*)—a candle lit in a Jewish house of mourning.

Olam Ha-Ba (Oh-*lam* Ha-*bah*)—the World to Come, a common name for the afterlife in Jewish tradition.

Onen (O-*nen*)—a Jewish mourner (plural: *Onenim*).

Pesach (Peh-*sakḥ*)—Passover, the Festival of Liberation from Egypt, celebrated for eight days in the spring.

Pidyon Ha-nefesh—literally, redeeming the soul—a ritual for health which involves Torah study and the giving of charity on behalf of the person who is ill.

Rav—A title of respect for a Jewish religious leader, often used interchangeably with rabbi.

Refuah Bedoka (Reh-fu-*ah* Be-du-*kah*)—the Jewish concept that only medical interventions with a reasonable chance of success should be implemented.

Sephardic Jews—Jews who trace their roots through lands dominated by Muslim culture.

Se'udat havra'ah (Se-u-*dat* Hav-rah-*ah*)—the first meal in a Jewish house of mourning, immediately after the burial.

Shabbat—the Sabbath, extending from Friday sundown through Saturday sundown; "Shabbos" in Yiddish.

Shavuot—The Feast of Weeks, celebrated for two days in the late spring; the model for the Christian holiday of Pentecost.

Sheitel (*Shay*-tel)—a wig worn by some observant married woman to cover their natural hair for reasons of modesty.

Shema (Sheh-*mah*)—a central Hebrew prayer affirming one's faith in God, often recited prior to death.

Shemirah (Sheh-mee-*rah*)—the practice of accompanying the body from the moment of death until the burial.

Shiva—the name for the first seven days following burial, during which mourners traditionally remain at home and receive condolence visits.

Shloshim—the name for the first thirty days following burial, during which mourners traditionally observe certain restrictions on their behavior.

Shoah (Sho-*ah*)—the Holocaust.

Shomer—the person who accompanies the body after death.

Sukkot—The Feast of Tabernacles, a harvest festival celebrated for eight days in the fall.

Tachrichin (Taḥ-ree-*hin*)—burial shrouds.

Taharah (Tah-ha-*rah*)—the process of washing and preparing a body for a traditional burial.

Tahor (Tah-*hor*)—pure, the term used to declare a corpse ritually pure after it has been prepared for burial.

Tallit (Tah-*leet*)—a prayer shawl; *Tallis* in Yiddish.

Talmud—a vast text containing rabbinic law, narrative, biblical exegesis and ethical guidance, compiled in ancient Babylonia.

Tefillin (Teh-*fee-leen*)—phylacteries, black boxes which contain biblical verses strapped to the arm and head during morning prayers.

Tehillim (Teh-*hee-leem*)—Psalms.

Tichel (*Tiḥ*-hel)—a scarf worn by some observant married women to cover their natural hair for reasons of modesty.

Tzeddakah (Tzeh-dah-*kah*)—charity.

Vidui (Vee-*du*-ee)—a traditional prayer of confession commonly recited prior to death.

Yarmulke (*Yar*-mul-kah)—see *Kippah*.

Yahrtzeit (*Yar*-tzeit)—the anniversary of a death.

Yiḥud (Yee-*ḥud*)—two members of the opposite sex alone in a room together; many Orthodox Jews avoid this situation with those outside of their immediate family.

Yizkor—literally, "One will remember"—a prayer service held four times a year in memory of those who have died.

Yom Kippur (Yom Key-*pur*)—The Day of Atonement, a day of prayer, fasting and seeking forgiveness, observed each fall.

Yom Niḥum (Yom Nee-*ḥume*)—literally, a day of consolation, a modified and shorted version of *shiva* which may follow some losses, including a stillbirth.

Author's Acknowledgments

Ben and Eli Goldman may be most responsible for my involvement this project. They contented themselves playing with plastic frogs and napping while their father Michael was able to convince me what an amazing team had been assembled at Duke University to create this guide. I want to thank each of the committee members for their fine Southern hospitality, astute insights, high tolerance for quirkiness and their deep desire to make this project as successful as possible. Erica Rothman deserves special mention as she had the unenviable task of serving as the liaison between the committee and me—relating everyone's comments and my responses with both accuracy and tact. Erica and Linda Belans also are responsible for collecting many of the narratives included.

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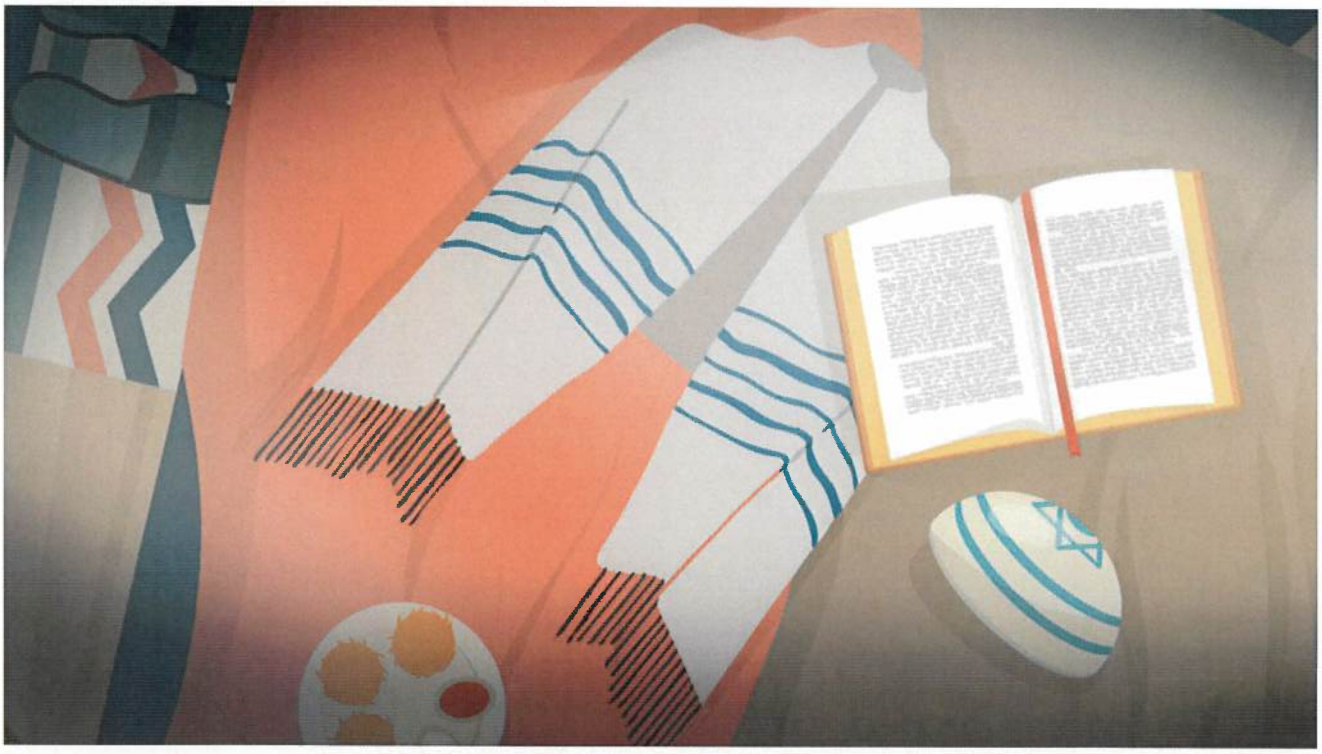
The Art of Dying Well

Jewish rituals for death and dying

A brief overview of Jewish beliefs and rituals in relation to death and dying.



Key points

1. Stay with the dying person
2. Help them to make peace with adversaries
3. Support them in making a deathbed confession

4. Encourage them to make the Jewish declaration of faith
5. It is never too late to turn to God

Jewish beliefs about death and dying

Most religious Jews believe that as they near the end of their lives, they should settle their affairs and make a will and that they should be reconciled with any family members with whom they have disagreed. They also believe they should make a deathbed confession and that their last words should be the Jewish declaration of faith. All Jewish denominations teach that the dying person should not be left alone.

Contact the Rabbi early

Rabbi Jonathan Romain of Maidenhead Synagogue in Berkshire is part of the Reform tradition. He says it is a good idea for a Jew to contact their rabbi when they receive a diagnosis of terminal illness.

Rabbi Romain says: "As a rabbi I can talk to them about any last wishes they may have or anything they want done. Have they made a will for instance? If they haven't, it could deprive their family of income and lead to friction.

"I can also help them to plan their funeral. Some people are very scared of mentioning that word while others find it quite comforting to plan what they want by way of music, readings and so on."

To make peace

Rabbi Romain advises the dying to make peace with those they have fallen out with.

"I will ask them if there is any unresolved conflict, particularly within the family. It is a time for being reconciled so you can die with an easy heart rather than regret," he says.

In both the Reform and Orthodox traditions, there is no requirement for a rabbi to be present at the bedside. Rabbi Romain says he is usually not contacted until after the person has died. However, he will always respond to a request from a dying person to visit.

Viddui prayer before death

When a dying person is nearing the end, they are encouraged to make a final confession known as the Viddui. This is an examination of conscience and a seeking of forgiveness from God.

The confession includes the following words: "I regret the hurts I have caused and the mistakes I have made. Forgive my sins and my soul will be pure as it returns to You. Protect those I love whom I leave behind, for their lives are in Your careâ€¦"

Rabbi Romain says a person can do this on their own or ask a friend or rabbi to help them.

Rabbi Stanley Coton, Senior Jewish hospital chaplain for Jvisit and an Orthodox rabbi says he is usually called to the bedside when a patient is approaching the end of their life.

"The person makes their confession when they are *in extremis* but we do say to them that many people have made the confession and lived on," Rabbi Coton says.

"If they are conscious, we explain that one of the teachings is that a person's passing into the next world is a cathartic experience. Seeking the forgiveness of sins is part of that experience and it is a time of reconciliation and atonement. The rabbi can do the confession with them or, if that isn't possible, say it for them. It should be said in Hebrew if possible. If not, the rabbi can give a synopsis in English.

"Most people make a general confession. I have never asked someone to list their sins but they can if they want to. My focus is to try to support them."

Never too late to turn to God

Rabbi Coton will also read psalms if requested by the patient. He adds that he will always go to a dying patient even if he is called to the hospital at the last moment by someone who has not practised their faith in recent years.

Jewish declaration of faith

The last words of a dying Jew should be the Shema. This is the Jewish declaration of faith that begins: Hear, O Israel, the Lord our God, the Lord is One (Deuteronomy 6:4). It is the most important declaration in Judaism and observant Jews say it at least twice a day.

> “Love doesn’t mean doing extraordinary or heroic things. It means knowing how to do ordinary things with tenderness.”
>
> Jean Vanier, Community And Growth

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Shalom Hospice is certified by the National Institute of Jewish Hospice (NIJH) proudly serving Knox, Anderson, Loudon, Blount, Sevier, and Jefferson counties. Our mission is to ensure that no Jewish patient or family faces a life limiting illness alone or without care. Shalom Hospice helps to ensure access to resources compatible with their own Jewish practices and beliefs.

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Chayim Aruchim

Chayim Aruchim חיים ארוכים
Center for Culturally Sensitive Health Advocacy & Counseling
A PROJECT OF AGUDATH ISRAEL OF AMERICA

Important message from Chayim Aruchim to family members regarding Hospice

Consultation with a knowledgeable Rav is necessary before a decision is made to admit the patient to hospice care. Once the decision is made that admitting the patient to hospice care is appropriate, you need to be mindful that while hospice care can offer certain benefits, it can also present its own set of Halachic challenges.

1. **Pain medications** - Pain medication will likely be offered/prescribed to relieve a patient's pain symptoms. Relieving pain is very important. It is important to note, however, that certain pain medications could cause respiratory suppression and expedite death, which is against halacha. The Rabbonim of Chayim Aruchim can assist you in your discussions with the physician about pain medications and making sure the patient receives appropriate care.

2. **Nutrition, Hydration and Medication – According to Halacha, nutrition and hydration (food and drink) must be provided to a patient in almost all cases.** When having a discussion about hydration and nutrition, make sure to ask a knowledgeable Rov before making any decisions. **In reference to medication,** any symptoms that might indicate infection or other illnesses should be treated . The Rabbonim of Chayim Aruchim can be particularly helpful in discussing the pertinent medical issues with your physician and medical staff, and can then guide you to make the most appropriate decisions according to Halacha.

3. **DNR and DNI orders** - When offered Do No Resuscitate (DNR) or Do Not Intubate (DNI) advanced care directives at ANY medical facility, **do NOT sign them UNLESS you first discuss the situation with a knowledgeable Rabbi.** Only a Halachic Medical Directive should be signed.

4. **CHAYIM ARUCHIM** - DO call Chayim Aruchim, ANY time you need us! We are here for you. There is simply too much at stake to "go it alone"! Chayim Aruchim has trained Rabbis in the field of Medical Halacha to discuss with, and advise, you and your physician.

Chayim Aruchim Hotline- 718-Aruchim(718-278-2446)
Hayim Aruchim Hotline - 347-578-8200

Revised 02/18/2021

Do learn as much as possible about your condition in order to get the best possible care.

If necessary, designate a family member to oversee your care and treatment if you are unable to do so yourself. It is important for the patient and/or the designee to learn as much as possible about the condition, to help get the best possible care, to learn about the Halachic ramifications of a selected course of care, to make decisions and interact with the medical professionals who are directly responsible for the care.

Do choose a Rabbi to be your Halachic advisor.

In the event of illness which chalilah, in the worst case scenario, may require end-of-life decisions, it is incumbent upon patients and their families to familiarize themselves with all potential options and to present these options to the family Rav, Posek or a competent Halachic authority for guidance.

Do not accept an offer from your health professional to discuss end-of-life options unless your Halachic advisor is involved in the process.

Legislation was recently passed in New York State requiring doctors and nurses caring for patients diagnosed with a terminal illness to offer information and counseling on the available options for palliative and end-of-life care. You may legally decline this offer. If you do choose to accept the offer, it is vital that your Rav be involved in the counseling session.

Do not relinquish your right to treatment without fully understanding what your treatment options are and how they may help you.

As a matter of policy, New York State gives patients significant rights with regard to their medical care. Health care facilities are required to accommodate every patients civil and religious liberties and must encourage and assist in the fullest possible exercise of these rights. To the extent that a

patients religious beliefs mandate a certain course of treatment, the patients family may need assistance to have the health care facility accommodate those wishes.

Do not choose palliative care and/or hospice services unless the provider respects Halacha and considers the Rabbi an integral part of the team.

If you choose palliative care and/or hospice services according to Halacha, then nutrition, hydration and other Halachic requirements should be provided. It is important to choose a palliative care/hospice that is sensitive to the needs of the religious patient, encourages the patient/family to consult with their Rav or Halachic authority, considers the Rav an integral member of the team, will consult with your designated physician regarding the dosages for morphine or other pain killers, and where there is ongoing supervision to assure continued adherence to Halacha.

Do not sign any of the hospital-offered advance care directives, or any such directives obtained from a lawyers office or other sources without consulting a Rav. Do sign a Halachic Medical Directive.

Advance directives typically include DNR (Do Not Resuscitate) and DNI (Do Not Intubate) orders. Be careful not to make decisions about any of these matters without consulting your Rav. The patient should sign an Agudath Israel of America Halachic Medical Directive. It helps ensure that all health care decisions for a patient will be made according to Halacha.

Do call Chayim Aruchim.

For appropriate counseling and advice that is based on Halacha, or for a free copy of the Agudath Israel Halachic Medical Directive, please contact the Chayim Aruchim Center for Culturally Sensitive End of Life Advocacy and Counseling. The program coordinator, Rabbi Aron Wajsfeld, can be reached directly at 718-535-9061 or by e-mail chayimaruchim@agudathisrael.org.

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- Prayer at the Cemetery on Behalf of Choleh
- Viduy of Chochmas Adam / Confession Before Death

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Halachic Medical Directive, Tennessee

The Halachic Medical Directive

PROXY AND DIRECTIVE WITH RESPECT TO HEALTH CARE AND POST-MORTEM DECISIONS

FOR USE IN THE STATE OF TENNESSEE

The "Halachic Medical Directive" is designed to help ensure that all medical and post-death decisions made by others on your behalf will be made in accordance with Jewish law and custom (*halacha*). The text of this Halachic Medical Directive has been approved by attorneys for use in your state as of February 2022. While we do not expect that any future change in federal or state laws would materially affect the validity of this document, you may wish to show it to your own attorney to confirm its effectiveness in subsequent years.

INSTRUCTIONS

(a) **Please print your name on the first line of the form.**

(b) **In Section 1, print the name, address, and telephone numbers of the person you wish to designate as your *agent*** to make medical decisions on your behalf if, G-d forbid, you ever become incapable of making them on your own. Be sure to include all contact information (including cell phone and e-mail) where your agent can be reached in the event of an emergency. If the contact information for your agent changes, you should provide that updated information to everyone whom you have provided with a copy of your Halachic Medical Directive.

You may also insert the name, address, and telephone numbers of an *alternate agent* to make such decisions if your main agent is unable, unwilling, or unavailable to make such decisions.

It is recommended that before appointing anyone to serve as your agent or alternate agent you should ascertain that person's willingness to serve in such capacity. In addition, if you have made arrangements with a burial society (*Chevra Kadisha*) for the handling and disposition of your body after death, you may wish to advise your agents of such arrangements.

Note: *Tennessee law allows virtually any competent person to serve as a health care agent.* Thus, you may appoint as your agent (or alternate agent) your spouse, adult child, parent or other adult relative.

The agent may not be the treating health care provider nor an employee of the treating health care provider, nor an operator of a treating health care institution nor an employee of an operator of a treating health care institution. However, an employee of the treating health care provider or an employee of an operator of a treating health care institution may be designated as the agent if the employee is your relative by blood, marriage or adoption.

A conservator may not be designated as the agent if you are their conservatee under the laws of this state where the conservatee has the power to execute legal documents, unless: (1) The power of attorney is otherwise valid; (2) You are represented by legal counsel; and (3) Your attorney signs a certificate stating in substance: "I am an attorney authorized to practice law in the state where this power of attorney was executed, and the principal was my client at the time this power of attorney was executed. I have advised my client concerning my client's rights in connection with this power of attorney and the applicable law, and the consequences of signing or not signing this power of attorney, and my client, after being so

advised, has executed this durable power of attorney for health care."

(c) **In section 3, please print the name, address, and telephone numbers of the Orthodox Rabbi whose guidance you want your agent to follow**, should any questions arise as to the requirements of *halacha*.

You should then print the name, address, and telephone numbers of the Orthodox Jewish institution or organization you want your agent to contact for a referral to *another* Orthodox Rabbi *if* the rabbi you have identified is unable, unwilling, or unavailable to provide the appropriate consultation and guidance. You are, of course, free to insert the name of any Orthodox Rabbi or institution/organization you would like, but before doing so it is advisable to discuss the matter with the rabbi or institution/organization to ascertain their competency and willingness to serve in such capacity. You may list Chayim Aruchim as the organization you select, phone number 718-ARUCHIM (718-278-2446).

(d) **On page 5, sign and print your name, address, phone numbers, and the date.**

(e) **This power of attorney is only valid if your signature is either attested by a notary public with no witnesses (on page 7) *or* witnessed by two witnesses without attestation by a notary public (on page 6).** Witnesses must be competent adults (i.e., at least 18 years old) and not the agent. At least one of the witnesses must be not related to you by blood, marriage, or adoption and would not be entitled to any portion of your estate upon your death under any will or codicil made by you existing at the time of execution of the durable power of attorney for health care or by operation of law then existing.

(f) It is recommended that you keep the original of this form among your valuable papers in a location that is readily accessible in the event of an emergency; and that you **distribute copies to the health care agent (and alternate agent)** you have designated in section 1, **to the rabbi and institution/organization** you have designated in section 3, as well as to **your doctors, your lawyer**, and anyone else who is likely to be contacted in times of emergency.

(g) We also recommend that you register a copy of this form with a national registry, so that it can be accessed by any health care facility via computer. This can be done for a fee by contacting the U.S. Living Will Registry at http://www.uslivingwillregistry.com/ or by calling 1-800-548-9455.

(h) If at any time you wish to revoke this Proxy and Directive, you may do so by executing a new one; or by notifying your agent or health care provider, orally or in writing, of your intent to revoke it. To avoid possible confusion, it would be wise to try to obtain all originals and copies of the old Proxy and Directive and destroy them. If you do not revoke the Proxy and Directive, Tennessee law provides that it remains in effect indefinitely. Obviously, if any of the persons whose names you have inserted in the Proxy and Directive dies or becomes otherwise incapable of serving in the role you have assigned, you should execute a new Proxy and Directive.

(i) It is recommended that you also complete the **Emergency Instructions Card** contained on the last page of this Halachic Medical Directive, and carry it with you in your wallet or purse.

(j) If, upon consultation with your rabbi, you would like to add to this standardized Proxy and Directive any additional expression of your wishes with respect to medical and/or post-mortem decisions, you may do so by attaching a "rider" to the standardized form. If you choose to do so, or if you have any other questions concerning this form, please consult an attorney.

These instructions are not part of the Halachic Medical Directive and need not be kept attached to the executed document.

Developed and published by: Agudath Israel of America • 42 Broadway, 14th Floor • New York, NY 10004 • 212-797-9000

PROXY AND DIRECTIVE WITH RESPECT TO HEALTH CARE DECISIONS AND POST-MORTEM DECISIONS

FOR USE IN THE STATE OF TENNESSEE

WARNING TO PERSON EXECUTING THIS DOCUMENT

- This is an important legal document. Before executing this document you should know these important facts.
- This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document.
- Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.
- Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.
- This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent: (1) authorizes anything that is illegal; or (2) acts contrary to your desires as stated in this document.
- You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital or other health care provider orally or in writing of the revocation.
- Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.
- Unless you otherwise specify in this document, this document gives your agent the power after you die to: (1) authorize an autopsy; (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes; and (3) direct the disposition of your remains.
- If there is anything in this document that you do not understand, you should ask an attorney to explain it to you.

I, _____, hereby declare as follows:

1. Appointment of Agent: In recognition of the fact that there may come a time when I will become unable to make my own health care decisions because of illness, injury or other circumstances, I hereby designate and appoint

Agent

Name of Agent:
_____

Address:
_____

Telephone: Home: _____ Work: _____

Cell: _____ E-mail: _____

as my health care agent to make any and all health care decisions for me, consistent with my wishes as set forth in this directive.

If the person named above is unable, unwilling or unavailable to act as my agent, I hereby appoint

Alternate Agent

Name of Alternate Agent:
_____

Address:
_____

Telephone: Home: _____ Work: _____

Cell: _____ E-mail: _____

to serve in such capacity.

This appointment shall take effect in the event I become unable, because of illness, injury or other circumstances, to make my own health care decisions. By this document I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

2. Jewish Law to Govern Health Care Decisions: I am Jewish. It is my desire, and I hereby direct, that all health care decisions made for me (whether made by my agent, a guardian appointed for me, or any other person) be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. Without limiting in any way the generality of the foregoing, it is my wish that Jewish law and custom should dictate the course of my health care with respect to such matters as the performance of cardio-pulmonary resuscitation if I suffer cardiac or respiratory arrest; the performance of life-sustaining surgical procedures and the initiation or maintenance of any particular course of life-sustaining medical treatment or other form of life-support maintenance, including the provision of nutrition and hydration; and the criteria by which death shall be determined, including the method by which such criteria shall be medically ascertained or confirmed.

3. Ascertaining the Requirements of Jewish Law: In determining the requirements of Jewish law and custom in connection with this declaration, I direct my agent to consult with the following Orthodox Rabbi and I ask my agent to follow his guidance:

Rabbi Name of Rabbi:

_____

Address:

_____

Telephone: Home: _____ Work: _____

Cell: _____ E-mail: _____

If such Orthodox Rabbi is unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, the following Orthodox Rabbi:

Rabbi Name of Rabbi:

_____

Address:

_____

Telephone: Home: _____ Work: _____

Cell: _____ E-mail: _____

If both of these Orthodox Rabbis are unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, an Orthodox Rabbi referred by the following Orthodox Jewish institution or organization:

Organization Name of Institution/Organization:

_____

Address:

_____

Telephone: _____ E-mail: _____

If such institution or organization is unable, unwilling or unavailable to make such a reference, or if the Orthodox Rabbi referred by such institution or organization is unable, unwilling or unavailable to provide such guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, an Orthodox Rabbi whose guidance on issues of Jewish law and custom my agent in good faith believes I would respect and follow.

4. Direction to Health Care Providers: Any health care provider shall rely upon and carry out the decisions of my agent, and may assume that such decisions reflect my wishes and were arrived at in accordance with the procedures set forth in this directive, unless such health care provider shall have good cause to believe that my agent has not acted in good faith in accordance with my wishes as expressed in this directive.

If the persons designated in section 1 above as my agent and alternate agent are unable, unwilling or unavailable to serve in such capacity, it is my desire, and I hereby direct, that any health care provider or other person who will be making health care decisions on my behalf follow the procedures outlined in section 3

above in determining the requirements of Jewish law and custom.

Pending contact with the agent and/or Orthodox Rabbi described above, it is my desire, and I hereby direct, that all health care providers undertake all essential emergency and/or life sustaining measures on my behalf.

5. Access to Medical Records and Information; HIPAA: I direct that all of my protected health information (as such term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) and other medical records shall be made available to my agent upon request in the same manner as such information and records would be released and disclosed to me, and my agent shall have and may exercise all of the rights I would have regarding the use and disclosure of such information and records. In the event that the authority of my agent has not yet been established, I authorize each of my health care providers to release and disclose all my protected health information and other medical records to the individual nominated hereunder as my agent for the purpose of determining my capacity to make my own health care decisions, including, without limitation, the issuance and release of any written opinion relating to my capacity that such person may have requested.

The foregoing direction and authorization shall supersede any prior agreement that I may have made with any of my health care providers to restrict access to or disclosure of my protected health information or other medical records, and shall expire with respect to any health care provider upon being revoked by me in a writing delivered to such health care provider.

6. Post-Mortem Decisions: It is also my desire, and I hereby direct, that after my death, all decisions concerning the handling and disposition of my body be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. For example, Jewish law generally requires expeditious burial and imposes special requirements with regard to the preparation of the body for burial. It is my wish that Jewish law and custom be followed with respect to these matters. I hereby willfully and voluntarily make known my desire that, in the event of my death, the disposition of my remains shall be controlled by my agent designated in section 1 above. In the event my agent is unable, unwilling or unavailable to act, I hereby appoint the alternate agent designated in section 1 above to control the disposition of my remains.

Further, subject to certain limited exceptions, Jewish law generally prohibits the performance of any autopsy or dissection. It is my wish that Jewish law and custom be followed with respect to such procedures, and with respect to all other post-mortem matters including the removal and usage of any of my body organs or tissue for transplantation or any other purposes. I direct that any health care provider in attendance at my death notify the agent and/or Orthodox Rabbi described above immediately upon my death, in addition to any other person whose consent by law must be solicited and obtained, prior to the use of any part of my body as an anatomical gift, so that appropriate decisions and arrangements can be made in accordance with my wishes. Pending such notification, and unless there is specific authorization by the Orthodox Rabbi consulted in accordance with the procedures outlined in section 3 above, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body.

7. Incontrovertible Evidence of My Wishes: If, for any reason, this document is deemed not legally effective as a health care proxy, or if the persons designated in section 1 above as my agent and alternate agent are unable, unwilling or unavailable to serve in such capacity, I declare to my family, my doctor and anyone else whom it may concern that the wishes I have expressed herein with regard to compliance with Jewish law and custom should be treated as incontrovertible evidence of my intent and desire with respect to all health care measures and post-mortem procedures; and that it is my wish that the procedure outlined in section 3 above should be followed in determining the requirements of Jewish law and custom.

8. Request to Medical Providers: I have made the decisions set forth in this document, particularly those stating that I want my health care decisions to be made by my health care agent (should I not be capable of making my own decisions) in accordance with Orthodox Jewish law in consultation with an Orthodox rabbi, after a great deal of thought and in view of my very deeply-held religious beliefs. I am aware that there may come a time when I am asked to reconsider these decisions, possibly when I am in a hospital or other institutional setting with serious health issues and my ability to think clearly and articulate my views has been compromised by illness, medication, or physical or emotional pain. If I am no longer capable of making my own decisions then of course I want my health care agent to make health care decisions for me. But if I am still capable of making my own decisions, while I wish to maintain autonomy to do so, I do not want to be subjected to pressure by any health care provider to change the position I have taken in signing this document. I therefore implore all medical providers to please (a) not try to persuade me to vary from the position I have articulated in this document and (b) if you are going to have a discussion with me about my health care decisions, that you only do so with my health care agent (or alternate agent) and if possible my rabbi as well, participating in the discussion, ideally in person or by phone if necessary, and with this document in front of you and read to me as part of that conversation.

9. Duration and Revocation: I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent will continue to exist until the time when I become able to make health care decisions for myself. My signature on this document shall be deemed to constitute a revocation of any prior health care proxy, directive or other similar document I may have executed prior to today's date.

SIGNATURE

My Signature Signature: _____

Print Name: _____

Date: _____

Address: _____

Telephone: Home: _____ Work: _____

Cell: _____ E-mail: _____

DECLARATION OF WITNESSES

Each of the witnesses states as follows:
I declare under penalty of perjury under the laws of Tennessee that the person who signed this document is personally known to me to be the Principal; that the Principal signed this durable power of attorney in my presence; that the Principal appears to be of sound mind and under no duress, fraud or undue influence; that I am not the person appointed as attorney-in-fact by this document; that I am not a health care provider, an employee of a health care provider, the operator of a health care institution nor an employee of an operator of a health care institution; that I am not related to the Principal by blood, marriage, or adoption; that, to the best of my knowledge, I do not, at the present time, have a claim against any portion of the estate of the principal upon his or her death; and, that, to the best of my knowledge, I am not entitled to any part of the estate of the Principal upon the death of the Principal under a will or codicil thereto now existing, or by operation of law.

Witnesses Witness 1:
SIGNATURE

_____

Print Name:

_____

Residing at:

_____

Date:

_____

Witness 2:
SIGNATURE

_____

Print Name:

_____

Residing at:

_____

Date:

_____

[Alternative to DECLARATION OF WITNESSES:]

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Tennessee }
} ss.
County of _____ }

On this_____day of_____, in the year_____, before me,_____ (here insert name of notary public) personally appeared_____(here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it, and appears to be of sound mind and free from duress.

NOTARY SEAL

_____
(Signature of Notary Public)

My commission expires: _____

Emergency Instructions

I, _____ have executed a "Halachic Medical Directive with respect to medical and post-mortem decisions, dated _____." Pursuant to my "Halachic Medical Directive" the persons listed on the reverse of this card are to serve as my agent and alternate agent, respectively, in making health care decisions for me if I become unable to do so on my own. I desire that all such health care decisions, as well as all decisions relating to the handling and disposition of my body after I die, should be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. If there is any questions regarding Jewish law and custom, my agent (or any other person making decisions for me) should consult with and follow the guidance of the rabbi identified on the reverse of this card, or as a second choice the rabbi referred by the institution/organization identified on the reverse of this card, or as a third choice an Orthodox Rabbi whose guidance my health care decision maker in good faith believes I would respect and follow. Pending contact with my agent and/or rabbi, I desire that health care providers should undertake all essential emergency measures on my behalf; and I desire that no autopsy, organ removal, or other post mortem procedure be performed on my body without authorization from my agent and/or rabbi.

Fold on the dotted line to create a double sided card

EMERGENCY INSTRUCTIONS

Agent:_____

Phone:_____

Cell:_____ E-mail:_____

Alternate Agent:_____

Phone:_____

Cell:_____ E-mail:_____

Rabbi:_____

Phone:_____

Cell:_____ E-mail:_____

Organization:_____

Phone:_____ E-mail:_____

1N - 2

Letters of Support

Glenwood Campus
725 Glenwood Drive
Suite E-790
Chattanooga, TN 37404
Tel: (423) 206-4140
Fax: (423) 206-4141

CHI Memorial Neuroscience Institute, Director

Thomas G. Devlin, MD, PhD, FSVIN

Inpatient Stroke Center Director

Ruchir A. Shah, MD

Neurohospitalists

Emily Decroos, MD
Abhishek Kengen, MD
Elizabeth Carol, DO
Nataria Pitiyanuvath. MD

Neurosurgery
Ranjith Babu, MD, MS
Mayshan Ghiassi, MD
Paul Hofman, MD

Interventional Neurology
Jussie Lima, MD

Inpatient Nurse Practitioners

Jennifer Patterson, PhD C, ACNP-BC, CCRN, FHN

Rafael Souchet, MSN, AGACNP-BC, FNP

Tracy Robertson, MSN, AGACNP-BC

Sara-Page Red, MSN, APRN, AGANP-BC, SCRN

Taylor Eldridge, MSN, APRN, AGACNP-BC

Diana Taylor, DNP, APRN, AGACNP-BC

Jasmine Patton, MSN, APRN, AGACNP-BC, CCRN

Stroke Coordinator
Erin Patterson, RN

Stroke Navigator
Julie Hamilton, BSN, CVRN, SRNSCRN,
Data Abstractor
Lauren Daniel, LPN

Outpatient Nurse Practitioner

Jennifer Bryan, MSN, FNP-BC,

CHI Memorial
Neuroscience Institute

Date: May 13, 2024

To:
Logan Grant
Health Facilities Commission
502 Deaderick Street
Nashville, TN

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE
CERTIFICATE OF NEED FOR HOSPICE SERVICES

Dear Mr. Grant:

My name is Dr Thomas Devlin. I currently serve as the Chief of the Neuroscience Institute at CHI Memorial Hospital, Chattanooga. My specialty and clinical care skills are focused on the diagnosis and treatment of stroke patients. I serve as the lead physician on numerous international projects including the development of Artificial Intelligence (AI) technology to diagnose stroke very rapidly and at low cost, and in developing improved clot busting medication for stroke. My research team is also widely known for their current work developing new stem cell treatments and other pharmaceuticals that act as 'neuroprotectants' for stroke victims. I'm also partnered with CHI Memorial's Center for Healthy Aging and professional staff to strengthen the Dementia-Alzheimer's programs and offerings and establish new practices to close gaps in coverage that exist in the Chattanooga region. On a national level, I am the co-director of the CommonSpirit national Neuroscience Collaborative. CommonSpirit is currently the second largest health care system in America, and it is my job to facilitate communication and medical partnership between over 200 hospitals throughout the country.

My patients are from Hamilton County and surrounding counties in Tennessee, including Marion, Sequatchie, Polk and Bradley Counties. As a neurologist with substantial numbers of both stroke and dementia patients, I am acutely aware of the need for certain specialized and high-quality end-of-life services for those with advanced stages of their conditions.

CHI Memorial
Neuroscience Institute

I was recently informed that Shalom Hospice is seeking regulatory approval to develop an in-home hospice program in southeast Tennessee. It operates similar programs in Middle Tennessee and the Greater Knoxville area. This hospice serves the special needs of the Jewish population. I am unaware of any existing hospice in our region which has a similar focus on the Jewish end of life traditions, rituals and practices. Given the richness of these traditions, and the spiritual and emotional support a Jewish faith-based hospice program will provide my Jewish patients, I am strongly in support of this initiative.

Coupled with its Jewish focus and programming, Shalom Hospice will also include some unique programs to meet the special needs of the Jewish population. Having learned about Shalom Hospice's virtual reality program, I find this very exciting as I know this will be of great benefit to patients. Virtual reality is an innovative way to bring a larger world to people who've found themselves limited to a room, or just a bed and Shalom Hospice is innovative for bringing this technology to its patients. Its virtual reality program is steeped in Jewish history and visitations to Jewish historical sites.

Shalom Hospice also has a service intense model of care that helps to avoid unwanted hospital re-admissions for patients. Their service intense hospice model enables the patient the opportunity to have a comfortable and peaceful passing right where they are, in their place of residence. This is of benefit to both Jews and non-Jews.

Please approve the Shalom Hospice CON application to provide end of life hospice services to my Jewish patients, the Jewish population throughout southeast Tennessee and others who will benefit from its spiritual programming. I would estimate that in any given month, we would identify between 1 and 5 patients or families who would benefit. I look forward to working with Shalom Hospice once it is licensed in our region.

Sincerely,

Thomas Devlin MD PhD

Thomas Devlin, MD PhD FSVIN
CHI Memorial Neuroscience Institute, Director
Chattanooga Center for Neurologic Research LLC, Director
Neuroscience Innovation Foundation, Medical Director
CommonSpirit, National Neuroscience Collaborative, Co-Director
Professor of Neurology, University of Tennessee Health Science Center
423-802-2075
devlinmdphd@gmail.com

Tennessee Valley
PAIN MANAGEMENT

6130 Shallowford Road
Suite 101
Chattanooga, TN 37421
Phone: 423.664.4635
Fax: 423.664.4640

1012 Executive Drive
Hixson, TN 37343
Phone: 423.486.1444
Fax: 423.664.4640

2700 Westside Drive NW
Suite 306
Cleveland, TN 37312
Phone: 423.473.0726
Fax: 423.664.4640

June 25, 2024

Mr. Logan Grant, Executive Director
Tennessee Health Facilities Commission
502 Deaderick Street, 9th Floor
Nashville, TN

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE LLC
CERTIFICATE OF NEED FOR JEWISH HOSPICE SERVICES

Dear Mr. Grant:

I am a pain medicine specialist in Chattanooga, TN and have more than 13 years of experience in the field. I currently work with Tennessee Valley Pain Management and am well versed in controlling pain including those in terminal stages of their diseases. I am affiliated with Parkridge Medical Center.

Given my medical role, I see many patients in need of end of life care. As a physician who is also Jewish, I have the opportunity to observe end of life care and am also sensitive to meeting the special religious needs of this minority population.

I was recently informed that Shalom Hospice is seeking regulatory approval to develop an in-home hospice program in Southeast Tennessee to serve the special needs of the Jewish population. I am unaware of any existing hospice which has a similar focus on the end of life traditions, rituals and practices. Given the richness of these traditions, and the spiritual and emotional support a Jewish faith based hospice program will provide my Jewish patients, I am strongly in support of this initiative.

Coupled with its Jewish focus and programming, Shalom Hospice will also include some unique programs to meet the special needs of the Jewish population. Having learned about Shalom Hospice's virtual reality program, I find this very exciting and it will benefit these patients. Virtual reality is innovative way to bring a larger world to people who've found themselves limited to a room, or just a bed and Shalom Hospice is innovative for bringing this technology to its patients. Shalom Hospice also has a service intense model of care that helps to avoid unwanted hospital re-admissions for patients. Their service intense hospice model enables the patient the opportunity to have a comfortable and peaceful passing right where they are, in their place of residence.

Given the uniqueness of this program, I am confident it will be a community benefit for our patients and the public at large. I would anticipate with the size of our practice, that we would identify between 1 and 4 patients per month, depending on the month, who might consider this hospice program. Please approve the Shalom Hospice CON application to provide end of life hospice services to my Jewish patients and the Jewish population throughout the Greater Chattanooga area. Thank you.

Sincerely,

Stephen Dreskin M.D

Stephen V. Dreskin, MD

erlanger
Urology

June 27, 2024

Logan Grant
Health Facilities Commission
502 Deaderick Street
Nashville, TN

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE
CERTIFICATE OF NEED TO ESTABLISH IN-HOME HOSPICE SERVICES

Dear Mr. Grant:

My name is Israel Franco, MD. I am a Pediatric Urologist at Erlanger, with over 30 years of experience in the field and been listed repeatedly among Castle Connolly's top doctors. I received my medical degree from Albert Einstein College of Medicine and fellowship-trained at Lurie Children's Hospital in Chicago. I am an early innovator in Robotic and laparoscopic surgery, and developed and pioneered surgical techniques for undescended testis, hypospadias, prune belly syndrome, and renal and reconstructive surgery in pediatric urology. My work in neurological aspects of urinary incontinence for children with and without injuries to the nervous system has changed how these problems are managed today.

I am proud to be affiliated with Erlanger in southeast Tennessee. Our community is a vibrant one. As a practicing Jew, I am also fully engaged with Jewish traditions and rituals here in our region.

I am also aware that one of our Rabbi had contacted Shalom Hospice to determine Shalom Hospice's interest in meeting the end-of-life care needs of our Jewish population. The transition from life to death in Jewish tradition involves rituals and practices that provide support and comfort to the dying and anchors them in their faith. Unfortunately, this solace through ritual has not been available in our region because existing end of life organizations dedicated to serving the sick and dying are not experienced in the many Jewish traditions surrounding the sick and dying. While those organizations provide meaningful services, they do not meet the end of life needs of our area's Jewish population.

Establishing a Jewish hospice program is critically important to meet the end of life needs of our community. Since this type of program is currently unavailable, establishing the program will not impact other providers but will in fact enhance hospice utilization amongst the overall population given the uniqueness of the program being proposed. Jewish patients and their families and caregivers' need for spiritual and cultural end of life care will only increase as our Jewish community ages.

erlanger
Urology

Our Jewish elderly and terminally ill should be able to access Jewish traditions, rituals and nuances when receiving end of life care after a terminal diagnosis. Given the richness of these Jewish traditions, and the spiritual and emotional support a Jewish faith-based hospice program will provide our Jewish population, I am strongly in support of this initiative.

Given the underserved Jewish population, and the fact no similar program exists, I urge the HFC to approve the Shalom Hospice CON application to establish a Jewish hospice program. Please approve that CON application so that our people will have access to appropriate faith-based end of life care. Thank you in advance.

Regards,

Israel Franco, MD

Israel Franco, MD

June 27, 2024

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

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE LLC
HOSPICE CON APPLICATION

Dear Mr. Grant:

My name is Martin Simms, MD. I am a physician in private practice in Southeast Tennessee. My wife, Shelley, and I live in Chattanooga. We have been active members in the community since 1996 and believe there is an unmet need in the Jewish community for specialized faith based hospice services.

We were recently introduced to Shalom Hospice, which a local Rabbi solicited to establish a Jewish hospice in our region. Our understanding is they have done so in Middle Tennessee and the Greater Knoxville area. Expanding to our region is appropriate, and importantly addresses a currently unmet need.

Hospices currently serving our community are not optimally familiar with Jewish culture, rituals, and traditions; and consequently are not ideally suited to ease the spiritual anguish of the dying and their families. We support the establishment of a new hospice in the Chattanooga area, serving Hamilton, Marion, Sequatchie, Polk and Bradley counties. There are between 3,000 and 4,000 of the Jewish faith in the region, and it is important to have a specialized Jewish hospice program serving these residents.

Without a doubt, the Jewish community will benefit from a hospice provider that is experienced with Jewish culture and customs.

Thank you in advance for allowing us to voice our support for a much-needed Jewish hospice provider in Southeastern Tennessee.

Sincerely,

Martin and Shelley Simms

Mr. Logan Grant, Executive Director
Tennessee Health Facilities Commission
502 Deaderick Street, 9th Floor
Nashville, TN

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE LLC
CERTIFICATE OF NEED FOR JEWISH HOSPICE SERVICES

Dear Mr. Grant:

I am a board certified nurse practitioner and have spent the majority of both my nursing and nurse practitioner career in critical care. By nature of this practice setting, and particularly during the COVID pandemic, I have spent a large amount of my job dealing with hospice and palliative care. Despite having such a large catchment area in Chattanooga at our tertiary care center, we do not have enough access to palliative and hospice care services. Patients distinctly feel more comfortable when they are able to spend their time at home and with their loved ones. Additional in-home hospice and palliative care services in this community would be very valuable to the Chattanooga community.

I was recently informed that Shalom Hospice is seeking regulatory approval to develop an in-home hospice program in Southeast Tennessee to serve the special needs of the Jewish population. I am unaware of any existing hospice which has a similar focus on the end of life traditions, rituals and practices. Given the richness of these traditions, and the spiritual and emotional support a Jewish faith based hospice program will provide my Jewish patients, I am strongly in support of this initiative.

Coupled with its Jewish focus and programming, Shalom Hospice will also include some unique programs to meet the special needs of the Jewish population. Having learned about Shalom Hospice's virtual reality program, I find this very exciting and it will benefit these patients. Virtual reality is innovative way to bring a larger world to people who've found themselves limited to a room, or just a bed and Shalom Hospice is innovative for bringing this technology to its patients. Shalom Hospice also has a service intense model of care that helps to avoid unwanted hospital re-admissions for patients. Their service intense hospice model enables the patient the opportunity to have a comfortable and peaceful passing right where they are, in their place of residence.

Given the uniqueness of this program, I am confident it will be a community benefit for our patients and the public at large. Given the acuity and large catchment area of our population, I am confident this will be a utilized service in our community. Please approve the Shalom Hospice CON application to provide end of life hospice services to my Jewish patients and the Jewish population throughout the Greater Chattanooga area. Thank you.

Karen E Hulley ACNP-BC

Karen E Hulley ACNP-BP, MSN, CCRN

Soddy-Daisy
HEALTHCARE CENTER

May 24, 2024

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

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE

Dear Mr. Grant:

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

By virtue of our location and our sponsorship, many of our patients have self-designated as being of the Jewish religion. As a nursing home operator, we provide support to these patients with their spiritual and emotional needs in accordance with our license. However, while we are licensed to provide skilled nursing services, we do not provide hospice end of life care.

The Jewish community has a rich history of visiting and comforting the sick and assisting them through death. The transition from life to death in Jewish tradition involves rituals and practices that provide support and comfort to the dying and anchors them in their faith. Unfortunately, this solace through ritual has not been available in our community because hospice organizations serving this area are not experienced in the many Jewish traditions surrounding the sick and dying.

However, Shalom Hospice that has an experienced, specialized team to service the Jewish community. In meeting with representatives from Shalom Hospice, it is my understanding that they are proposing a hospice in Southeast Tennessee to have a special emphasis on serving Jewish patients in end of life care. This is a service currently not available by existing providers and is a much-needed service. It would be a significant benefit to our community.

Shalom Hospice has demonstrated knowledge about Jewish traditions and rituals which enables them to relate to the spiritual needs of the Jewish community. Moreover, there are many patients at the end of life who cannot communicate well and most providers cannot penetrate the walls of dementia patients and those in a coma. Shalom Hospice not only connects patients to their religious roots but also through music therapy and virtual reality programs penetrates and touches their souls. It thus brings comfort to the most vulnerable of the Jewish population.

To that end, I have reviewed Shalom Hospice's proposed virtual reality program and their plan to have special Jewish focused virtual reality programs. The programs discussed with me that will benefit residents of Soddy Daisy Healthcare Center include historical footage of Jewish immigrants arriving in Ellis Island, Jewish shtetls in Poland, Russian, Ukraine and Galicia, Jewish ghettos in the Middle Ages, liberation of Auschwitz by American soldiers, modern Jewish life in America and modern Israel, among others. The

investment in this type of technology to bring comfort and support to our Jewish patients in end of life care will be significant and meaningful. The bereaved families will also be able to participate in these activities.

As the operator of Soddy Daisy Healthcare Center, I strongly advocate for the approval of a hospice in Southeast Tennessee that has an emphasis on serving Jewish patients. Based on Shalom Hospice's planned programming, and our resident profile, I would expect our facility and its physicians will refer an average of at least 2 patients per month to Shalom Hospice.

For the benefit of our Jewish patients, our other patients who are interested in spiritual programming and the entire Jewish community in Southeast Tennessee, please approve the Shalom Hospice CON application to meet the special end of life needs of the Jewish population of our community.

Thank you,

Ray Allen
Administrator

Life Care Center of Cleveland

3530 Keith Street N.W./Cleveland, TN 37312
(423) 476-3254/FAX (423) 476-5974/LCCA.com

June 5, 2024

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

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE

Dear Mr. Grant:

I am the Director of Social Services at Life Care Center of Cleveland. We are a 142-bed licensed nursing home. We are located in Bradley County at 3530 Keith Street, Northwest, Cleveland, TN. Our residents are primarily southeast Tennesseans, from Bradley and surrounding communities. More than half our patients are TennCare with the remainder being Medicare and other payors.

As part of our operations, some of our patients regularly benefit from hospice services. While we provide skilled nursing services, we are not licensed to provide hospice end of life care. Therefore we work collaboratively with these organizations.

We recently had the opportunity to meet with Shalom Hospice which is seeking to meet the needs of an underserved population in our area. We support this endeavor and encourage you to approve their CON application. Shalom Hospice programs of interest that will benefit our patients include its virtual reality, music therapy and service intensity.

Its virtual reality program allows patients and families to 'travel' and also includes a specific Jewish program for the Jewish population.

Shalom Hospice has a music therapy program that includes a board certified music therapist which will be an excellent benefit.

Its service intensity represents the level of patient touches; I find that excellent at 5 to 7 Home Health Aide visits per week, minimum of 2 RN visits per week and social worker and Rabbi (if the patient and family want a spiritual visit) at least weekly, which helps to keep families and loved ones well supported. Their rapid response to referrals will also be welcome 7 days per week. Based on our patients and knowledge of our community, I would anticipate referrals to Shalom Hospice will likely range between 2 and 3 per month.

Please approve Shalom Hospice to provide hospice services in southeast Tennessee.

Thank you,

Lydia Sandberg

Lydia Sandberg
Director of Social Services

Ascension Living

Alexian Village

Logan Grant
Health Facilities Commission
502 Deaderick Street
Nashville, Tennessee

Dear Mr. Grant:

I want to take a moment to express my support for a proposed new hospice program to be established by Shalom Hospice of Southeast Tennessee. I am a Chaplain with Ascension Living's Alexian Village Health and Rehabilitation Center, 622 Alexian Way, Signal Mountain, Hamilton County. We are a 114-bed skilled nursing facility serving a diverse population in southeast Tennessee. We a part of the Alexian Village, a retirement village with independent living units, amenities and facilities for active and aging seniors.

I recently had the pleasure of meeting a representative of Shalom Hospice which is seeking CON approval to establish a specialized hospice program in our region to meet the needs of the underserved Jewish population as well as others throughout our community. As a Chaplain I was particularly interested in their spiritual programming, how that component of their hospice plan reaches the terminally ill in their final journey and how they work with the family members both during the illness and then after the passing of their loved ones.

The Shalom program is unique in its programming as there is not another such program in our region. Any Jewish patients we have would surely benefit from Shalom's programs, principals and protocols. In fact, other spiritually minded patients may also have an interest once Shalom receives its CON approval.

I look forward to the Health Facilities Commission approving Shalom Hospice so that we may work with Shalom Hospice when appropriate.

Thank you for your consideration.

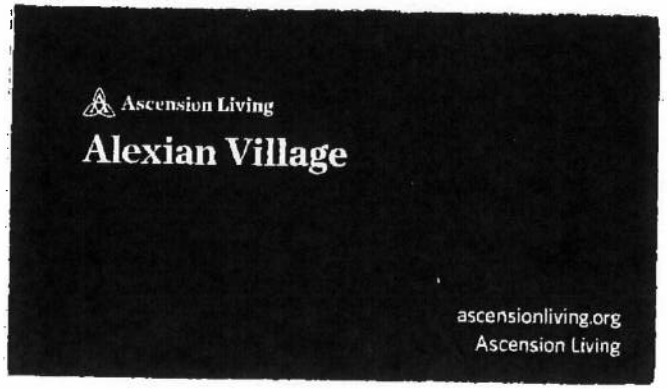
Sincerely,

Margaret Ferguson

Margaret Ferguson, Chaplain

437 Alexian Way
Signal Mountain, TN 37377

423-886-0100
ascensionliving.org



Margaret Ferguson
Chaplain
Mission Support

Alexian Village of Tennessee
437 Alexian Way
Signal Mountain, TN 37377

margaret.ferguson@ascension.org

t 423-517-9574
m 423-280-3554

ValleyView
13960 highway 28
Whitwell, Tn 37397
423-658-0100

June 5, 2024

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

RE: Shalom Hospice of Southeast Tennessee - Certificate of Need Application

Dear Mr. Grant:

I am the Director of Nursing for Valley View Assisted Living, the only assisted living facility in Marion County. We are located at 101 North Maple St, Whitwell, TN. We are an 80-bed facility serving Marion and surrounding counties.

It is my understanding that Shalom Hospice is proposing a new hospice program in our community. I have had the opportunity to discuss the Shalom Hospice proposal with its representatives and believe it will be an outstanding service provider addition in Marion County.

Shalom Hospice is seeking to meet some very specific underserved needs but will also admit any hospice appropriate patient that seeks its services, whether driven by its spiritual programming, service intensity or specialty programs. Each of these facets of its proposal are of interest to us as we believe our residents, when appropriate for referral, will benefit from rapid response, nearly daily patient touches, spiritual programming, music therapy and virtual reality. Given our resident profile, these referrals may number 1 to 3 per quarter.

I look forward to Valley View Assisted Living having the opportunity to work collaboratively with Shalom Hospice. To enable this, please approve Shalom Hospice's proposal to establish a new hospice program. Thank you for allowing me to provide input into the CON decision.

Sincerely,

Alicia Condra

Alicia Condra, DON

Director of Nursing

June 27, 2024

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

Re: Shalom Hospice of Southeast Tennessee
Hospice CON Application

Dear Mr. Grant:

My name is Bebe Kennedy, VP of Clinical Services, and I represent Morning Pointe Senior Living. We operate assisted living facilities throughout middle and east Tennessee. Our assisted living facilities are focused on meeting the needs of frail elderly in a nurturing, supportive and program rich environment.

We had the opportunity of being introduced to Shalom Hospice, which operates highly specialized hospices in Middle Tennessee and its most recent addition in the Knoxville area. We understand that Shalom Hospice is now applying to expand its offerings to our region, including the Chattanooga and Cleveland MSAs. Within this region, we operate the following assisted living facilities:

- Morning Pointe of Chattanooga
- Morning Pointe of Collegedale at Greenbriar Cove
- Morning Pointe of Hixson
- Morning Pointe of Chattanooga at Shallowford
- Morning Pointe of East Hamilton
- The Lantern at Morning Pointe

We are supportive of the HFC approving the Shalom Hospice application for several pertinent reasons which will benefit Morning Pointe residents and the community at large. Our reasons for this support are based on Shalom Hospice's referral response time, service intensity and spiritual programming. These factors are highlighted below.

- Respond to all referrals within one hour, initiate the assessment process within two hours, and expedite admission to the hospice subject to having a physician order in hand and the patient/family selecting the hospice option.
- 5 to 7 Home Health Aide visits per week, provided this is acceptable to the IDT, patient and family.
- Minimum of 2 RN visits per week, provided this is acceptable to the IDT, patient and family.
- Provide a social worker and chaplain/Rabbi (if the patient and family want a spiritual visit) at least weekly, which helps to keep families and loved ones well supported.
- Increased visit frequency during the final weeks of life to provide support.
- Offering a comprehensive spiritual program for Jewish residents and other residents who are spiritually minded and interest in devotion in their final journey.

With the above as Shalom Hospice's service commitment, we expect, based on our residents in our numerous facilities throughout this region, that each facility would likely have on average at least 1 referral per month.

We strongly urge you to approve Shalom Hospice to provide hospice services that will fill a void in available end of life care in our community. Thank you for your consideration.

Sincerely,

Bebe Kennedy
Vice President of Clinical Services

EAST HAMILTON
Morning Pointe
Assisted Living & Memory Care

1776 Generations Way • Ooltewah, TN 37363
(423) 212-1208

June 5, 2024

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

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE
CERTIFICATE OF NEED APPLICATION

Dear Mr. Grant:

I am the Executive Director of Morning Pointe of East Hamilton, in Hamilton County Tennessee. We design each Morning Pointe Senior Living community to provide our residents with the personal care they need to feel supported while maintaining their independence. At Morning Pointe we believe that seniors deserve the best care possible so that they can live a more joyful life including access to hospice care. We have both assisted living and memory care programs.

Recently, I met with Shalom Hospice and learned about their initiative to establish a hospice program in southeast Tennessee. They have a similar program in both Middle Tennessee and the Greater Knoxville area. Their goal is to meet the needs of the underserved religious minority but will serve all denominations. Shalom Hospice's approach is comprehensive, and its tailored programs will be valuable to our community.

Shalom's service intensity is impressive. I learned that they have a quick response time to all new referrals. As the Executive Director, I know that will only enhance the accessibility to hospice care for all of my residents. Their service intensity of boots at the bedside with almost daily patient touches is notable and a program differentiator. 5 to 7 aide visits per week, RN twice weekly and weekly social worker and chaplain/Rabbi will benefit each of our residents who requires hospice care. I was also impressed with their specialty programs of music therapy and virtual reality. These are unique programs they will offer to all patients at no cost regardless of funding. Given our resident profile and community, I would expect referrals to average 1 per month.

Morning Pointe of East Hamilton looks forward to working with Shalom Hospice and strongly supports their mission and application to establish a hospice program in our community. I appreciate your consideration in this matter.

Sincerely,

Ian Shives
Senior Executive Director

DOMINION™
SENIOR LIVING

May 28, 2024

Mr. Logan Grant
Executive Director
Health Facilities Commission
502 Deaderick Street, 9th Floor
Nashville, TN

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE LLC
CERTIFICATE OF NEED FOR JEWISH HOSPICE SERVICES

Dear Mr. Grant:

I am the Wellness Director for Dominion Senior Living of Hixson, located at 2143 Northpoint Boulevard, Hixson, Hamilton County. Our assisted living facility is licensed for 67 beds, 32 of which are specialized for residents with Alzheimer's and other forms of dementia.

I recently learned about Shalom Hospice that has an experienced, specialized team to service the Jewish community. They began providing these services in Middle Tennessee early last year and most recently in the Knoxville area. It is my understanding that they are proposing a hospice in the Greater Chattanooga area to have a special emphasis on serving Jewish patients in end of life care. This is a service currently not available by existing providers and is a much-needed service. It would be a significant benefit to our community since Hamilton and the surrounding counties have most of the Jewish population in our region.

Shalom Hospice has demonstrated knowledge about Jewish traditions and rituals which enables them to relate to the spiritual needs of the Jewish community. Moreover, there are many residents at the end of life who cannot communicate well and most providers cannot penetrate the walls of those residents with dementia. Shalom Hospice not only connects residents to their religious roots but also through music therapy and virtual reality programs which penetrate and touch their souls. It thus brings comfort to the most vulnerable of the Jewish population. I am in favor of the HFC approving Shalom Hospice for the following reasons:

- Supporting the Jewish population in my facility and in our region, including the terminally ill and their families.
- Providing music therapy by a board certified music therapist with frequent visits, with the program including historical Jewish singing, prayers and other ties to Jewish heritage;
- Responding to referred patients within two hours of receiving the referral, seven days per week.
- Interacting with its patients almost daily each week provides another set of clinical and watchful eyes for our residents, including those with dementia. Its care teams see

patients 5 to 7 days per week by aides, minimum two visits per week by RN, and weekly visits by social workers and chaplains/rabbis.

Each of these programmatic features are of interest to me and our facility; they will enhance access to hospice services for my residents.

As the Wellness Director, I strongly advocate for the approval of Shalom Hospice with its emphasis on serving Jewish patients and providing a service intensity and specialty programming that will benefit all patients.

For the benefit of our residents and the overall community, please approve the Shalom Hospice CON application to meet the special end of life needs.

Thank you,

Tess Greer, LPN
Wellness Director

REGENCY HOUSE
Where you've always been.

Sharon Scott, LPN
Resident Care Director
scott@hixsonregencyhouse.com

2062 Hamill Road
Hixson, TN 37343

PHONE (423) 870-0050
FAX (423) 870-1558

May 22, 2024

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

Re: **Shalom Hospice of Southeast Tennessee, Hospice CON Application**

Dear Mr. Grant:

My name is Sharon Scott and I am the Resident Care Director for our 54-bed Regency House Assisted Living Facility located at 2062 Hamill Road, Hixson, Hamilton County. I have had the opportunity to learn about Shalom Hospice and its specialized programming. Their specialized services of interest to me on behalf of my residents include the following.

- Its Service Intensity of interacting with its patients almost daily each week provides another set of clinical and watchful eyes for our residents. My understanding is that Shalom Hospice's care teams see patients 5 to 7 days per week by aides, minimum two visits per week by RN, and weekly visits by social workers and chaplains/rabbis.
- Shalom Hospice also responds to referred patients in crisis within two hours of receiving the referral. All other patients are seen within the day. This will enhance access to hospice services for my residents.

This level of service intensity is not available in our region; we therefore embrace it as we know it will benefit our residents and their families.

Additionally, Shalom Hospice is spiritually oriented given its origin and focus on incorporating religious beliefs into its care program. I believe some of our residents will also embrace this important facet of Shalom Hospice's programming. When approved and licensed, we intend on working with Shalom Hospice to introduce its specialized programming at our facility.

Please approve their CON Application for Southeast Tennessee. If you have any questions, please do not hesitate to contact me.

Sincerely,

Sharon Scott, LPN

Sharon Scott
Resident Care Director

BROOKDALE
—SENIOR LIVING SOLUTIONS—

June 25, 2024

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

Re: Shalom Hospice of Southeast Tennessee -- Hospice CON Application

Dear Mr. Grant:

I am the Health and Wellness Director of Brookdale Mount Vernon in Cleveland Tennessee. We have had the opportunity of being introduced to Shalom Hospice, which operates highly specialized hospices in Middle Tennessee and its most recent addition in the Knoxville area. We understand that Shalom Hospice is now applying to expand its offerings to our region, including the Chattanooga and Cleveland MSAs. We are supportive of the HFC approving the Shalom Hospice application for several pertinent reasons which will benefit our Brookdale community.

Our reasons to support Shalom Hospice's CON application are as follows:

- Its service intensity which we understand includes the following patient touches on an ongoing basis:
    - 5 to 7 Home Health Aide visits per week, provided this is acceptable to the IDT, patient and family.
    - Minimum of 2 RN visits per week, provided this is acceptable to the IDT, patient and family.
    - Provide a social worker and chaplain/Rabbi (if the patient and family want a spiritual visit) at least weekly, which helps to keep families and loved ones well supported.
    - Increased visit frequency during the final weeks of life to provide support.
    - Respond to all referrals within one hour, initiate the assessment process within two hours, and expedite admission to the hospice subject to having a physician order in hand and the patient/family selecting the hospice option.
- Virtual reality: This is a highly unique program for our area and will enable residents to benefit from travel when they are physically no longer able to do so. This will also benefit the patients' families.
- Music therapy: This will not only benefit the hospice patients but also other residents of our facility who are able to listen to this music programs.

1775 Mount Vernon Drive NW
Cleveland, TN 37311
Phone (423) 473-7300
www.brookdale.com
Facility #: 17810

With Shalom Hospice's service commitment as detailed above, we expect to refer at least one patient per month to Shalom Hospice. We strongly urge you to approve Shalom Hospice to provide hospice services that will fill a void in available end of life care in our community. Thank you for your consideration.

Sincerely,

Rachel Southerland, BSN, RN
Health and Wellness Director

1775 Mount Vernon Drive NW
Cleveland, TN 37311
Phone (423) 473-7300
www.brookdale.com
Facility #: 17810

Preferred Care at Home®

June 26, 2024

Logan Grant
Health Facilities Commission
502 Deaderick Street
Nashville, Tennessee

Dear Mr. Grant:

My name is Bill Tobin and I am the Client Care Manager for Preferred Care at Home of Chattanooga–a licensed provider of non-medical, personal care services based in Hamilton County. As one of the area's leading home care agencies, we owe our 15 year track record of success to the special attention we pay to our clients' individualized needs for personal happiness and spiritual fulfillment above all else.

I want to express my support for a proposed new hospice program with whom we share these values: Shalom Hospice of Southeast Tennessee. This hospice is seeking Certificate of Need approval to establish a specialized hospice program in our region to meet the needs of the underserved Jewish population as well as others with unique spiritual needs.

The comprehensive, broad spectrum of essential end-of-life services that Shalom Hospice has planned for the older adult population of Southeast Tennessee would truly be unique in our market. Our agency is particularly interested in their spiritual programming, how that component of their hospice plan reaches the terminally ill in their final journey, and how their team will work with family members, both during the illness and after the passing of their loved ones.

Given the geographic footprint of the market we cover and the base of clients and families we serve, I anticipate that we would enjoy a mutual collaboration with Shalom Hospice as referring partners once they are granted licensure. I look forward to the Health Facilities Commission approving Shalom Hospice so that we may work with Shalom Hospice when that time comes.

Thank you for your consideration.

Warm regards,

Bill Tobin
Client Care Manager

1400 McCallie Ave., Suite 220, Chattanooga, TN 37404
(423) 531.8696 · billtobin@preferhome.com · ChattanoogaSeniors.com
Celebrating life, dignity and independence™

Home Instead

June 28, 2024

Logan Grant
Health Facilities Commission
502 Deaderick Street
Nashville, Tennessee

Dear Mr. Grant:

My name is Savannah Burkhart, and I am the General Manager for Home Instead in Chattanooga, TN. Our home care services can help aging adults stay engaged in everyday life with tailor-made support by professional caregivers to stay safe and well at home.

I want to express my support for a proposed new hospice program to be established by Shalom Hospice of Southeast Tennessee. This hospice is seeking CON approval to establish a specialized hospice program in our region to meet the needs of the underserved Jewish population as well as others who are spiritual and reside throughout this region.

Shalom Hospice's service intensity is unique and not currently available in our region.. It will be of particular interest to our home care clients and their families. In terms of service intensity, we understand the Shalom Hospice program includes the following patient touches on an ongoing basis:

Respond to all referrals within one hour, initiate the assessment process within two hours, and expedite admission to the hospice subject to having a physician order in hand and the patient/family selecting the hospice option.
5 to 7 Home Health Aide visits per week, provided this is acceptable to the IDT, patient and family.
Minimum of 2 RN visits per week, provided this is acceptable to the IDT, patient and family.
Provide a social worker and chaplain/Rabbi (if the patient and family want a spiritual visit) at least weekly, which helps to keep families and loved ones well supported.
Increased visit frequency during the final weeks of life to provide support.
Offering a comprehensive spiritual program for Jewish residents and other residents who are spiritually minded and interest in devotion in their final journey.

Given our home care footprint and patients we are referred and/or admit, I would expect there to be mutual collaboration with Shalom Hospice including referral of appropriate patients on a regular basis. I look forward to the Health Facilities Commission approving Shalom Hospice so that we may work with Shalom Hospice when appropriate.

Thank you for your consideration.

Sincerely,

Savannah Burkhart
General Manager

Chabad
Chattanooga

May 10, 2024

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

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE
CERTIFICATE OF NEED APPLICATION HOSPICE SERVICES

Dear Mr. Grant:

My name is Rabbi Shaul Perlstein and I am honored to be the Rabbi of Chabad of Chattanooga. I have been the Rabbi of Chabad of Chattanooga and the Jewish community in the Greater Chattanooga area since 2009, approximately 15 years. The origins of today's Chabad-Lubavitch organization can be traced to the early 1940s, when the sixth Lubavitcher Rebbe, Rabbi Yosef Yitzchak Schneersohn of righteous memory (1880–1950), appointed his son-in-law and later successor, Rabbi Menachem Mendel, to head the newly founded educational and social service arms of the movement. Motivated by his profound love for every Jew and spurred by his boundless optimism and self-sacrifice, the Rebbe set into motion a dazzling array of programs, services and institutions to serve every Jew.

Today over 5,000 full-time emissary families (2,000 in the United States) apply 250-year-old principles and philosophy to direct more than 3,500 institutions (and a workforce that numbers in the tens of thousands) dedicated to the welfare of the Jewish people worldwide.

Chabad of Chattanooga is located at 950 Vine Street, Chattanooga, Tennessee, serving Hamilton and surrounding counties, including Sequatchie, Marion, Bradley and Polk. Residing throughout this area, I estimate there are between 3,000 and 4,000 Jewish persons representing all stream of the Jewish religion – Orthodox, Conservative, Reform and Unaffiliated. Throughout my time in southeast Tennessee, I have ministered to congregants and the community in each of the noted counties throughout their lives. My services include officiating at funerals, being with families during the last moments of loved ones, transmitting bodies to other locations for burial, among other near ed or end of life services.

Chabad
Chattanooga

I am the Director of the Jewish Burial Society of Chattanooga; it is known as Chevra Kadisha, which I describe below. I am also a Credentialed Clergy of Greater Chattanooga (CCGC). In that role, I visit all hospitals in Hamilton County. Additionally, as CCGC, I visit nursing homes and assisted living facilities, including (but not limited to) Alexian, Life Care Centers, Ashwood and many others. In Bradley County I visit the Tennova Hospital and Avail Senior Living. These facility visits are in addition to the countless homes I visit from throughout our region, both in state and out of state, and particularly in the five counties in which Shalom Hospice is seeking approval to meet the end of life needs of the Jewish population to whom I minister.

I have some unique perspectives relative to end of life care for Jewish patients. First, during my tenure as Rabbi, I have been called many times to hospitals, nursing homes and private residences to attend to the needs of actively dying Jewish patients. Some of these Jewish community members are on hospice, while others are not. Those on hospice are not provided with services consistent with Jewish laws, rituals and culture. I have witnessed firsthand the passing of a Jewish person, and the hospice unable to meet the dying person and family's needs. The lack of culture and understanding can be upsetting and unsettling to Jewish patients and families.

Second, while called upon by families to attend to end of life care, despite being in this region for 15 years, I have never been called by any of the hospices in this region to provide spiritual services to any of their patients. This further confirms my opinion that the Jewish person is unserved, or underserved, relative to the provision of end of life hospice care.

My third perspective of the need for Jewish focused end of life programming is that I am the Director of the local Chevra Kadisha. Chevra Kadisha is a sacred burial society which cares for the Jewish deceased and prepares them for burial in a manner that is consistent with Jewish law. In that capacity, I have come to see firsthand the incredible need for an organization like Shalom Hospice that provides for the Jewish end of life needs.

From a geographic perspective, I am called upon to minister with Jewish persons throughout southeast Tennessee, in addition to Hamilton County. In Hamilton County, I am very active with the hospitals, nursing homes and assisted living facilities. Similarly, in Bradley County I frequent Tennova Hospital and senior living facilities. Throughout this region, there are more than 3,000 persons of the Jewish faith and I respond to all situations including those involving the passing of one of our community members, regardless of their affiliation.

As the Rabbi and through Chevra Kadisha, I am in a position to evaluate the end-of-life needs of Jewish patients and measure the quality of end-of-life services. I am acutely aware of

Chabad
Chattanooga

cultural sensitivities and nuances that make for comfortable and peaceful passing. I am intimately familiar with Jewish customs, in general, and end-of-life issues in particular. Therefore, I can state with full conviction that existing hospice providers are not culturally sensitive to the needs of Jewish patients and families. They have been lacking in the spiritual and religious needs of the Jewish community.

Shalom Hospice understands the unique requirements of the Jewish population relative to end of life rituals, traditions and customs. For Jewish patients and their families, Shalom Hospice will provide personalized care within the framework of Jewish law and ritual. For example, a central feature of the Jewish ritual for the dying is recitation of Vidui, the Confessional Prayer Before Death. Shalom Hospice, in a very sensitive manner, encourages saying Vidui to give the dying person the chance to confess sins and ask for forgiveness. Shalom Hospice assists the dying and the family by taking religious and spiritual needs into account.

Based on my 15 years of experience as a member of the Jewish clergy in the Chattanooga area, I would expect there to be substantial referrals of Jewish community members and friends to Shalom Hospice, including through our organizations, Chabad of Chattanooga and Chevra Kadisha.

Given the absence of end of life hospice services to meet the needs of dying Jewish patients in southeast Tennessee, I strongly urge the Tennessee Health Facilities Commission to approve the certificate of need application by Shalom Hospice to establish a hospice in this region of the state. We are grateful for your consideration and are available to respond to any questions you may have. Thank you.

Very truly yours,

Rabbi Shaul Perlstein

Chabad of Chattanooga
950 Vine St. Chattanooga, TN 37403
www.JewishChatt.com | 423.490.1106 | info@jewishchatt.com

June 16, 2024

Logan Grant
Health Facilities Commission
502 Deaderick Street
Nashville, TN

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE
CERTIFICATE OF NEED FOR HOSPICE SERVICES

Dear Mr. Grant:

My name is Rabbi Sam Rotenberg. I am the Senior Rabbi at B'nai Zion Congregation. We are a conservative temple located at 923 McCallie Avenue, Chattanooga. Established in 1880s as Brethren from B'nai Chein, an orthodox congregation. The congregation's name was changed to B'nai Zion in 1924. In 1961, it changed its affiliation from orthodox to conservative, which it remains today. We have a robust community with a mission to provide the Greater Chattanooga a community dedicated to the celebration of conservative Jewish life inspired by Torah, education and tikkun olam.

As the Senior Rabbi of our congregation, I am involved in many facets of my congregants' lives. One of the most stressful tasks is dealing with the terminally ill, and hospice is no different. It is my experience that the hospices currently serving our congregants are not familiar with Jewish cultures, rituals, and traditions. The returning of one's soul to God at the end of its journey in this world is the most profound moment in a person's life. It is said that there are no atheists in a foxhole.

Similarly, when faced with death the human soul craves the solace found in religion. At that moment of truth as the soul approaches eternal life in heaven, religion becomes a source of comfort and peace. Most end-of-life providers are not familiar with Jewish rituals and customs and consequently are unable to ease the spiritual anguish of the dying and their families.

I understand that Shalom Hospice is seeking approval to establish a new hospice in southeast Tennessee to serve Hamilton, Marion, Sequatchie, Polk and Bradley Counties. With between 2,000 and 3,000 Jews in this area, it is particularly important to have a specialized Jewish hospice program available to meet their end of life needs.

I've reviewed information provided regarding Shalom Hospice and their vision and mission to serve our Jewish community. I am impressed by their knowledge of the Jewish culture and what they plan to implement. Whether to recite Vidui and Shema or gather a quorum for saying Kaddish, Shalom Hospice assured me that they will be there and will provide services in a most respectful and appropriate manner.

As part of Shalom Hospice's programming, I also look forward to them hosting educational programs for our constituents, and also utilizing their team members to provide bereavement support to our families regardless of whether their family members were Shalom Hospice patients. This will be a great service for the entire community.

Without a doubt, the Jewish community and others will benefit from a hospice provider that is experienced with the Jewish cultures and customs. Please approve Shalom Hospice's application for the Certificate of Need. Thank you in advance for allowing me to voice my support for Shalom Hospice, a much-needed Jewish hospice provider.

I'll add one more thing. Since I took over at B'nai Zion Congregation, I have felt supported in helping our congregation navigate the complicated emotions and technicalities after someone dies. Before they pass, I have heard many complaints about how our local hospice care does not treat them in a way that honors their Jewish identity. Not to disparage the good work they do – they just do not fully understand how to frame dying in a Jewish way. I look forward to being able to offer Shalom Hospice as an option so our congregants feel supported not only after they pass, but also in the days and weeks preceding their departure from this earth.

Sincerely,

Rabbi Sam Rotenberg
Senior Rabbi, B'nai Zion C

Congress of the United States
Washington, DC 20515

June 3, 2024

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

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE
CERTIFICATE OF NEED APPLICATION TO ESTABLISH IN-HOME HOSPICE SERVICES

Dear Mr. Grant:

I represent Tennessee's Third Congressional District which includes 10 counties: Anderson, Bradley, Campbell, Hamilton, McMinn, Monroe, Morgan, Polk, Roane, and Scott.

I am aware that one of our local Rabbis contacted Shalom Hospice to determine Shalom Hospice's interest in meeting the end-of-life care needs of the Jewish population in Southeast Tennessee. The Rabbi was aware that Shalom Hospice had established similar hospices in Middle Tennessee and most recently in the Greater Knoxville area. I wholeheartedly support this effort to bring these services to this area.

The transition from life to death in Jewish tradition involves rituals and practices that provide support and comfort to the dying and anchors them in their faith. Unfortunately, this solace through ritual has not been available because existing end-of-life organizations dedicated to serving the sick and dying are not experienced in the many Jewish traditions related to late-stage care. While those organizations provide meaningful services, they do not meet the end-of-life needs of our local Jewish population.

Establishing a Jewish hospice program is critically important to meet the end-of-life needs of the Jewish population. Since this type of program is currently unavailable, establishing the program will not impact other providers but will in fact enhance hospice utilization amongst the overall population given the uniqueness of the program being proposed. Jewish patients and their families and caregivers' need for spiritual and cultural end of life care will only increase as our Jewish community ages.

Our Jewish elderly and terminally ill should be able to access Jewish traditions, rituals and nuances when receiving end of life care after a terminal diagnosis. Given the richness of these Jewish traditions, and the spiritual and emotional support a Jewish faith-based hospice program will provide our Jewish population, I am strongly in support of this initiative.

Given the underserved Jewish population, and the fact no similar program exists, I urge the HFC to give all due consideration the Shalom Hospice CON application to establish a Jewish hospice program here in Southeast Tennessee and enable more members of our community to have access to appropriate faith-based end-of-life care. Thank you in advance.

Respectfully yours,

Charles "Chuck" J. Fleischmann
Member of Congress
Tennessee Third District

PRINTED ON RECYCLED PAPER

Kevin M. Spiegel, FACHE
3350 SW 27th Avenue
Suite 1907
Miami Fl, 33133
423-802-8693
Kmsfache@gmail.com

June 21, 2024

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

RE:Shalom Hospice of Southeast Tennessee
Hospice CON Application for Persons of the Jewish Faith

Dear Mr. Grant:

I am pleased to provide my total support for the Shalom Hospice to establish a new hospice in southeast Tennessee. By way of background, my name is Kevin Spiegel. I previously had the pleasure to serve as the Chief Executive Officer for Erlanger Health System and Assistant Professor of Medicine at the University of Tennessee.

The transition from life to death in Jewish tradition involves rituals and practices that provide support and comfort to the dying and anchors them in their faith. Existing hospices in southeast Tennessee are not experienced in the many Jewish traditions surrounding the sick and dying. While the existing hospices provide meaningful services for some population groups, they do not meet the end of life needs of this area's Jewish population. Those who are diagnosed as terminally ill – and Jewish – are underserved at their most vulnerable point in their lives, as they near the end with terminal diagnoses.

Having a Jewish hospice to meet these specialized end of life needs of the Tennessee's Jewish population is of utmost importance to guide these people through their transition from life to death. I understand the HFC previously approved similar hospices to serve Middle Tennessee and the Greater Knoxville area.

It is now important the HFC does the same for the Greater Chattanooga area and allow Shalom Hospice to establish a Jewish hospice to meet the end of life needs of our Jewish population.

Jewish patients and their families and caregivers need for spiritual and cultural end of life care will only increase as our Jewish community ages. Our Jewish community will benefit from having access to a Jewish hospice program; such a program does not exist so many of these persons have unmet needs in end of life. Shalom Hospice has a full understanding of the unique requirements of the Jewish population and will implement its specific hospice program to meet the special needs of Jewish people in end of life care.

Shalom Hospice will provide personalized care within the framework of Jewish law and ritual. Shalom Hospice will assist the dying and the family by taking religious and spiritual needs into account. Having a Jewish hospice to not only provide the hospice care and innovative related programming, but also associated bereavement services is important to our community and we would appreciate all your assistance to this end.

I am in full support of Shalom Hospice's application for the certificate of need to develop a Jewish hospice program in southeast Tennessee and provide a necessary, currently unavailable, service for the Jewish community. Thank you in advance for approving the Shalom Hospice CON application.

Sincerely,

Kevin M. Spiegel, FACHE
Assistant Professor Drexel College of Medicine
President & CEO Medical Expansion Partners
Chaplain, United States Chaplain Corps

May 12, 2024

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

RE: Shalom Hospice of Southeast Tennessee
Hospice CON Application for Persons of the Jewish Faith

Dear Mr. Grant,

My name is Sarah Aronson. I have the pleasure of serving the community of Hamilton County as a paramedic on a 911-only ambulance service and also serve on our area's Jewish Burial Society, known as Chevra Kadisha. I have two unique perspectives relative to end of life care for Jewish patients. First, as a paramedic, I have seen firsthand actively dying Jewish patients that were not served properly by our local hospices. This is in part due to the fact that most hospice services are not based around jewish faith and therefore do not know or understand our customs regarding end of life care.

My second view of the need for Jewish focused end of life programming is that I serve on our area's Chevra Kadisha. Chevra Kadisha is a sacred burial society which cares for the Jewish deceased and prepares them for burial in a manner that is consistent with Jewish law. In that capacity, I have come to see firsthand the incredible need for an organization like Shalom Hospice that provides for the Jewish end of life needs. There are very few of us here in Hamilton County who fully understand and have the capabilities of handling jewish burial preparations.

Given these two complementary roles, I am in a position to evaluate the end-of-life needs of Jewish patients and measure the quality of end-of-life services. I am acutely aware of cultural sensitivities and nuances that make for comfortable and peaceful passing within the jewish faith. I am intimately familiar with Jewish customs, in general, and end-of-life issues in particular. Therefore, I can readily state that existing hospice providers are not culturally sensitive to the needs of Jewish patients and families. They have been lacking in the spiritual and religious needs of the Jewish community.

Shalom Hospice understands the unique requirements of the Jewish population relative to end of life rituals, traditions and customs. For Jewish patients and their families, Shalom Hospice will provide personalized care within the framework of Jewish law and ritual. For example, a central feature of the Jewish ritual for the dying is recitation of Vidui, the Confessional Prayer before Death. Shalom Hospice, in a very sensitive manner, encourages saying Vidui to give the dying person the chance to confess sins and ask for forgiveness. Shalom Hospice assists the dying and the family by taking religious and spiritual needs into account.

Based on my experiences, I would expect there to be substantial referrals of Jewish community members and friends to Shalom Hospice through the various Jewish organizations in our region.

Given the absence of end of life (hospice) services to meet the needs of dying Jewish patients, I strongly urge the HFC to approve the certificate of need application by Shalom Hospice to establish a jewish hospice in Southeast Tennessee. We are grateful for your consideration and are available to respond to any questions you may have. Thank you.

Warm regards,

Sarah Aronson, EMT-P
#215437

Thomas P. Balázs
145 Inland Drive
Atlanta, GA 30342
(773) 677-3385 (Cell)
thomasbalazs@yahoo.com

May 28, 2024

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

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE LLC, HOSPICE CON APPLICATION

Dear Mr. Grant:

Please accept my letter of support for Shalom Hospice's ongoing effort to obtain approval to offer its hospice care services in Southeast Tennessee. I'm a Professor of English at the University of Tennessee at Chattanooga (UTC) and serve as an advisor for Jew–TC, a Jewish organization for students at UTC.

I was interested to learn that Shalom Hospice intends to offer its accredited program here in the Chattanooga area. Thousands of years of Jewish tradition provide guidelines helping people manage the end-of-life period of crisis—prayers, rituals, and religious symbols that most Jews observe at least in part. It's important that hospices educate and train their employees about these practices and customs when serving Jewish end-of-life patients. That's why it's vital for our region of Tennessee to offer Jewish hospice services.

I understand that volunteerism is also an important part of the hospice Medicare program. Our vibrant student community could share their diverse talents with families, whether through music, writing, or other forms of service. Furthermore, the potential for internships in various fields, such as nursing, chaplaincy, social work, and business administration, would provide invaluable opportunities for our students.

All told, our Jewish community would benefit immensely from a hospice provider experienced with Jewish cultures and customs. I'm deeply grateful for the opportunity to voice UTC and Jew-TC support for a much-needed Jewish hospice provider to come to our area. Thank you for considering our request.

Sincerely,

Thomas P. Balazs PHD, MFA
Professor, University of Tennessee, Chattanooga

SOUTHERN UNION CONFERENCE
SEVENTH-DAY ADVENTIST CHURCH

June 29, 2024

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

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE LLC
HOSPICE CON APPLICATION

Dear Mr. Grant:

My name is Manuel V. Mendizabal. I am an emeritus ordained minister in good standing with the Southern-Day Adventist Church (Southern Union Conference) and World Radio Ambassador. I transitioned from Pastor to Pastor Emeritus when I decided to pursue my Jewish heritage and now observe Judaism.

Given my unique history, I have a front row seat to various religious denominations and recognize the importance of abiding by rituals and traditions, regardless of what faith someone ascribes to.

I had the great fortune of meeting a representative of Shalom Hospice which is seeking CON approval to establish a specialized hospice program in our region to meet the needs of the underserved Jewish population as well as others throughout our community. Given my position, I was particularly interested in their spiritual programming, how that component of their hospice plan reaches the terminally ill in their final journey and how they work with the family members both during the illness and then after the passing of their loved ones.

Towards the end of life, we find many in our community turning to their traditions. The Shalom program is unique in its programming as there is not another such program in our region. Having a hospice that is sensitive to and knowledgeable of Jewish practice and tradition could be immensely helpful at this time of life. Any Jewish patients and their families would surely benefit from Shalom's programs, principals and protocols. Especially in this time of escalated antisemitism, it is particularly important to have an organization that understands Jewish traditions, rituals and culture. Additionally, other spiritually minded patients may also have an interest once Shalom receives its CON approval.

I urge and encourage you to approve the Shalom Hospice application to establish a hospice in the Greater Chattanooga area to serve Jewish persons and their families throughout southeast Tennessee. Thank you in advance for your vote.

Sincerely,

Manuel V. Mendizabal
AWR Ambassador, General Conference of Seventh Day Adventist Church
Emeritus Ordained Minister, Southern Union Conference of Seventh Day Adventist Church

PONDERS
FUNERAL HOMES

"Opening Our Home to Your Family In Time Of Need"

May 15, 2024

Mr. Logan Grant

Executive Director

Health Facilities Commission

502 Deaderick Street

Nashville TN

RE: SHALOM HOSPICE OF SOUTHEAST TENNESSEE
CERTIFICATE OF NEED APPLICATION TO ESTABLISH IN-HOME
HOSPICE SERVICES

Dear Mr. Grant:

My name is Stonewall Ponders. I am the owner of Ponders Funeral Homes, the primary funeral source for the Jewish residents of southeast Tennessee. Ponders Funeral Homes was established in northwest Georgia in 1992. As a graduate of Gupton-Jones College of Funeral Service and member of the Pi Sigma Eta National Morticians Fraternity, I realized a lifelong dream of owning my own funeral home. This dream became reality when we began serving Dalton area families in 1992.

To serve families in Tennessee, the Brainerd (Hamilton County) location of Ponders Funeral Home opened in 2018. This location features a chapel capable of accommodating 400 guests, as well as several parlors that are available for viewings and visitations. Located at 4203 Brainerd Road, Ponders Funeral Home is proud to be able to serve families in and around Chattanooga, TN.

SELECTED Independent FUNERAL HOMES® Member by Invitation

138 Melrose Drive • Dalton, Georgia 30721 • Ph: 706-226-4002 • Fax: 706-226-7936
675 Jolley Road • Calhoun, Georgia 30701 • Ph: 706-625-7577 • Fax: 706-625-7580
2566 Hwy 411 • Fairmount, Georgia 30139 • Ph: 706-337-3784 • Fax: 706-337-3768
4203 Brainerd Rd. • Chattanooga, Tennessee 37411 • Ph: 423-531-4002 • Fax: 423-498-2112

Members of International Order of the GOLDEN RULE

Stoney Ponders
President

PONDERS
FUNERAL HOMES

"Opening Our Home to Your Family In Time Of Need"

As a family owned and operated business, Ponders Funeral Home strives to assist families in creating a memorable and sophisticated service to celebrate the life of your loved one. Offering a wide variety of options for personalization and willing to work within a family's financial needs, you can feel confident in knowing that the memory of your loved one will be handled with honor and respect.

As the founder of Ponders, I understand and am acutely aware of cultural sensitivities and nuances that make for comfortable and peaceful passing. I am somewhat familiar with Jewish customs, both preceding death and after passing based on my 30+ years in the business. The area's Jewish population who become terminally ill should be afforded the opportunity to have in-home end of life hospice services consistent with their religious beliefs. Assuredly, based on my perspective, I can state that the existing hospice providers have not been culturally in tune with the needs of Jewish patients and families and been lacking in the spiritual and religious needs of the Jewish community.

Furthermore, I regularly counsel the bereaved as a funeral director. Having an available Jewish hospice program to provide bereavement services for 13 months from passing, in accordance with Medicare requirements, would be an outstanding resource for me to introduce to the many constituents I encounter from my position with Ponder Funeral Homes.

Shalom Hospice has focused on establishing programs and services which are aligned with the cultural, tradition, and rituals required in meeting the end of life needs of the Jewish population. The organization has demonstrated its caring staff and innovative programs guide the patients and their families through the age old rituals offering comfort and support and affirming Jewish identity and connection. The Southeast Tennessee community would be well served if Shalom Hospice is awarded a Certificate of Need to provide end of life care to Jewish patients, including long term bereavement services for the survivors.

SELECTED Independent FUNERAL HOMES® Member by Invitation

138 Melrose Drive • Dalton, Georgia 30721 • Ph: 706-226-4002 • Fax: 706-226-7936
675 Jolley Road • Calhoun, Georgia 30701 • Ph: 706-625-7577 • Fax: 706-625-7580
2566 Hwy 411 • Fairmount, Georgia 30139 • Ph: 706-337-3784 • Fax: 706-337-3768
4203 Brainerd Rd. • Chattanooga, Tennessee 37411 • Ph: 423-531-4002 • Fax: 423-498-2112

Member of International Order of the GOLDEN RULE

Stoney Ponders
President

PONDERS
FUNERAL HOMES

"Opening Our Home to Your Family In Time Of Need"

In my capacity, I strongly advocate for the approval of Shalom Hospice. Shalom Hospice would fill a great void and dire need for the Jewish community. Please approve Shalom Hospice's application for the Certificate of Need to develop a hospice program in our region. Thank you for your consideration of this request.

Sincerely,

Stonewall Ponders

Founder, Ponder Funeral Homes

SELECTED Independent FUNERAL HOMES® Member by Invitation

138 Melrose Drive • Dalton, Georgia 30721 • Ph: 706-226-4002 • Fax: 706-226-7936
675 Jolley Road • Calhoun, Georgia 30701 • Ph: 706-625-7577 • Fax: 706-625-7580
2566 Hwy 411 • Fairmount, Georgia 30139 • Ph: 706-337-3784 • Fax: 706-337-3768
4203 Brainerd Rd. • Chattanooga, Tennessee 37411 • Ph: 423-531-4002 • Fax: 423-498-2112

Member of International Order of the GOLDEN RULE

Stoney Ponders
President

May 31, 2024

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

RE: Shalom Hospice of Southeast Tennessee
Proposed Hospice Program

Dear Mr. Grant:

My name is Christine Duncan. I am a retired teacher and have been a resident of Marion County, Tennessee since 1997. Given my age and experience, I am quite familiar with healthcare resources throughout this area.

I have had the pleasure of learning about Shalom Hospice, a proposed faith-based hospice program seeking State approval to license and operate a proposed hospice. It has identified persons of the Jewish faith in this region as underserved and wants to bring specific faith based programming and spiritual services to meet the needs of this population. It will also offer a non-denominational aspect of its overall and spiritual programming as it will admit all patients, regardless of religion.

Shalom Hospice will be different than other providers with its specialized programming and services. It plans to have music therapy, virtual reality and equine therapy. It will also have a service intensity different than other providers which includes 5 to 7 aid visits per week, weekly visits by social worker and chaplain and twice weekly by nurses. This kind of patient and family engagement will benefit consumers in this region.

As a consumer, I recommend you approve the Shalom Hospice CON application to provide our community with these additional resources. Its program will benefit the consumers of Marion and other counties in our region.

Thank you.

Sincerely,

Christine Duncan

Christine Duncan

May 31, 2024

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

RE: Shalom Hospice of Southeast Tennessee
Proposed Hospice Program

Dear Mr. Grant:

My name is Zachary Summit. I have been a resident of Marion County since 2007. As a resident of the Greater Chattanooga area, I have an understanding of available healthcare services in our area.

I recently learned about Shalom Hospice, a proposed faith-based hospice program seeking State approval to license and operate a proposed hospice. It has identified religious minorities (persons of the Jewish faith) as underserved and wants to bring specific faith based programming and spiritual services to meet the needs of this population. It will also offer a non-denominational aspect of its overall and spiritual programming as it will admit all patients, regardless of religion.

My understanding is that Shalom Hospice will differentiate its services from other providers by offering almost daily patient visits, music therapy, virtual reality, and equine therapy.

As a consumer in this area, I recommend you approve the Shalom Hospice CON application to provide our community with these additional resources. Its program will benefit the consumers of Marion and other counties in our region.

Thank you.

Kind regards,

Zachary Summit

3A

Proof of Publication

Form v1.52

Chattanooga Times Free Press

Account #: AP104402
Company: BRADLEY ARANT BOULT
1221 Broadway Ste 2400
Nashville, TN 37203-7238
Ad number #: 411067
PO #:
Matter of: NOTIFICATION OF INTENT

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:

Times Free Press 06/14/24; TimesFreePress.com 06/14/24

And that there is due or has been paid the CHATTANOOGA TIMES FREE PRESS for publication the sum of $239.32.

Samara Swafford

Sworn to and subscribed before me this date:14th day of June, 2024

SHENIQUA HAMBRICK STATE OF TENNESSEE NOTARY PUBLIC HAMILTON COUNTY MY COMMISSION EXPIRES DECEMBER 14, 2026

Sheniqua Hambrick

My Commission Expires 12/14/2026

Chattanooga Times Free Press

400 EAST 11TH ST
CHATTANOOGA, TN 37403

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 Shalom Hospice of Southeast Tennessee LLC, a/an Hospice Agency owned by Shalom Hospice of Southeast Tennessee LLC with an ownership type of Limited Liability Company and to be managed by itself intends to file an application for a Certificate of Need for Shalom Hospice of Southeast Tennessee LLC, a newly formed hospice agency with an ownership type of limited liability company, which is jointly owned by Samuel Stern and the SYGS 2023 Trust, and will be self-managed, 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 Hamilton, Marion, Sequatchie, Bradley and Polk Counties. While the hospice agency will not discriminate against members of any religion (or any other protected class), the hospice agency will have a specific emphasis on serving persons of the Jewish faith.. The address of the project will be 1200 Premier Drive, Suite 210, Chattanooga, Hamilton County, Tennessee, 37421. The estimated project cost will be $500,000.

The anticipated date of filing the application is 07/01/2024

The contact person for this project is Attorney Michael Brent who may be reached at Bradley Arant Boult Cummings, LLP - 1221 Broadway, Suite 2400, Nashville, Tennessee 37203 – Contact No. 615-252-2361.

The published Letter of Intent must contain the following statement pursuant to T.C.A. §68-11-1607 (c)(1).(A) Any healthcare 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 Coenmission meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application may file a written objection with the Health Facilities Commission at or prior to the consideration of the application by the Coenmission, or may appear in person to express opposition. Written notice may be sent to: Health Facilities Commission, Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243 or email at hsda.staff@tn.gov .

411067-1

LEGAL NOTICES

LEGAL NOTICES

7A

Articles of Organization

001537660

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY

SS-4270

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
(615) 741-2286

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

For Office Use Only
-FILED-
Control # 001537660

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: Shalom Hospice of Southeast Tennessee 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:
SHALOM HOSPICE OF GREATER KNOXVILLE LLC
5409 MARYLAND WAY SUITE 212
BRENTWOOD, TN 37027
WILLIAMSON 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: 2

9. Period of Duration: Perpetual

10. The complete address of the Limited Liability Company's principal executive office is:
2302 QUENTIN ROAD
BROOKLYN, NY 11229

B1557-5665 05/02/2024 2:04 PM Received by Tennessee Secretary of State Tre Hargett

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY

SS-4270

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
(615) 741-2286

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

For Office Use Only
-FILED-
Control # 001537660

The name of the Limited Liability Company is: Shalom Hospice of Southeast Tennessee LLC

11. The complete mailing address of the entity (if different from the principal office) is:
2102 AVENUE Z, SUITE 201
BROOKLYN, NY 11235

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	Member
Signature	Title/Signer's Capacity
Samuel Stern	May 2, 2024 2:04PM
Printed Name	Date

B1557-5666 05/02/2024 2:04 PM Received by Tennessee Secretary of State Tre Hargett

7A

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

Shalom Hospice of Southeast Tennessee LLC
2102 AVENUE Z, SUITE 201
BROOKLYN, NY 11235

May 2, 2024

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

SOS Control # :	**001537660**	Formation Locale:	TENNESSEE
Filing Type:	Limited Liability Company - Domestic	Date Formed:	05/02/2024
Filing Date:	05/02/2024 2:04 PM	Fiscal Year Close:	12
Status:	Active	Annual Report Due:	04/01/2025
Duration Term:	Perpetual	Image # :	B1557-5665
Managed By:	Member Managed		

Document Receipt

Receipt # : 008976478	Filing Fee:	$300.00
Payment-Credit Card - State Payment Center - CC #: 3873344522		$300.00

Registered Agent Address:
SHALOM HOSPICE OF GREATER KNOXVILLE LLC
5409 MARYLAND WAY SUITE 212
BRENTWOOD, TN 37027

Principal Address:
2302 QUENTIN ROAD
BROOKLYN, NY 11229

Congratulations on the successful filing of your **Articles of Organization** for **Shalom Hospice of Southeast Tennessee LLC** in the State of Tennessee which is effective on the date shown above. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee. Please visit the Tennessee Department of Revenue website (www.tn.gov/revenue) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and receive it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

7A

Certificate of Corporate 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

June 12, 2024

PATTI GREENBERG
PATTI GREENBERG
#950
999 PONCE DE LEON BLVD
CORAL GABLES, FL 33134-3047

Request Type: Certificate of Existence/Authorization
Request #: 0587353

Issuance Date: 06/12/2024
Copies Requested: 1

Document Receipt

Receipt # : 009052600	Filing Fee: $20.00
Payment-Credit Card - State Payment Center - CC #: 3875850166	$20.00

Regarding: **Shalom Hospice of Southeast Tennessee LLC**

Filing Type:	Limited Liability Company - Domestic	Control # :	1537660
Formation/Qualification Date:	05/02/2024	Date Formed:	05/02/2024
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

Shalom Hospice of Southeast Tennessee 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.

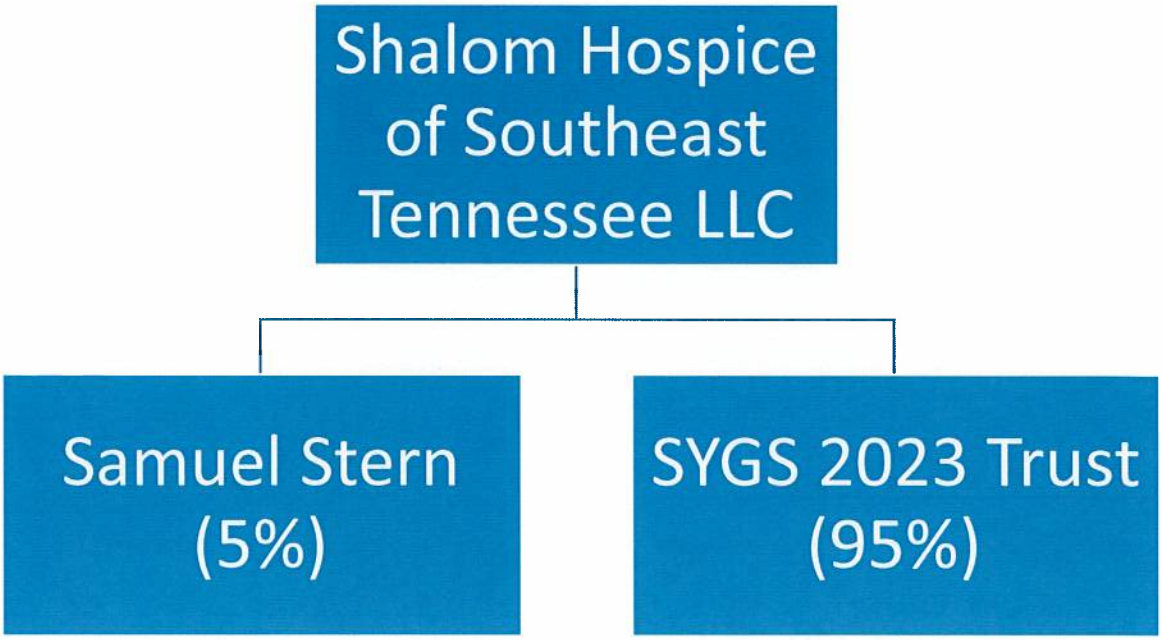
Tre Hargett
Secretary of State

Processed By: Cert Web User

Verification #: 068045420

7A

Organizational Chart


Shalom Hospice of Southeast Tennessee LLC
Samuel Stern (5%)
SYGS 2023 Trust (95%)

9A

Lease

LEASE AGREEMENT

THIS LEASE made as of this 4th day of June, 2024 ("Effective Date") by and between **1200 POINTE CENTRE PARTNERS, GP**, a general partnership (hereinafter referred to as "Landlord"), and **SHALOM HOSPICE OF SOUTHEAST TENNESSEE, GP**, a Tennessee limited liability company whose address is 2302 Quentin Road, Brooklyn, New York 11229 (hereinafter referred to as "Tenant").

W I T N E S S E T H:

Subject to all the terms, provisions and conditions herein contained, Tenant hereby rents from Landlord office space comprising a portion of the second floor of the 1200 Building ("Building"), being Suite 210 1200 Premier Drive, Chattanooga, Tennessee 37421, (with no easement for light or air being included in the Premises, as hereinafter defined) as outlined on the floor plan attached hereto as Exhibit "A" and made a part hereof (such space being hereinafter referred to as "Premises").

The following stipulations are hereby declared to be conditions of this Lease, and shall, unless otherwise expressly stated, be applicable at all times throughout the term of this Lease and any extensions thereof, and are mutually agreed upon:

1. Lease Term.

(a) The term of this Lease (herein called the "Lease Term") (1) shall commence on the date (herein called the "Commencement Date") which shall be the earlier to occur of (i) October 1, 2024 (as extended in accordance with paragraph 3(d) hereof) or (ii) the date on which the Premises are "Ready for Occupancy" as defined in Section 3 hereof, and (2) shall continue for a period of sixty-three (63) months, ending on the last day of the month which is sixty-three (63) months following the Commencement Date (herein called the "Expiration Date"), or on such earlier date upon which the Lease Term shall expire or be canceled or terminated pursuant to any of the conditions or covenants of this Lease or pursuant to law. Landlord and Tenant agree to confirm in writing the Commencement Date.

(b) For the purposes of this Lease, the term "Lease Year" means any twelve-month period of the Lease Term, which commences on the Commencement Date or any anniversary thereof.

2. Rent.

(a) During the Lease Term, Tenant agrees to pay to Landlord an annual rental on a full-service gross lease for each Lease Year in the dollar amount set forth below, subject to periodic adjustment, as provided hereinafter, for increases in Annual Operating Cost, as hereinafter defined (the amount of said annual rental being hereinafter called "Annual Base Rental):

Approx. RSF	Months of Term	Rate Per Sq. Ft.	Estimated Annual Base Rental	Estimated Monthly Base Rental
2,425	1-3	$0.00	$0.00	$0.00
	4-12	$23.00	$41,831.25	$4,647.92
	13-24	$23.69	$57,448.25	$4,787.35
	25-36	$24.40	$59,171.70	$4,930.97
	37-48	$25.13	$60,946.85	$5,078.90
	49-63	$25.89	$62,775.25	$5,231.27

*Exact Rentable Square Footage to be determined upon substantial completion of Premises as set forth above and Annual Base Rental shall be adjusted accordingly and the Lease shall be amended to reflect such adjustment.

The Annual Base Rental shall be payable in equal monthly installments as shown in the table above except as adjusted and amended to reflect the actual size of the Premises which are due in advance on the first day of each calendar month during the Lease Term. Such payments shall be made to Landlord at its principal offices as set forth in the Notice section hereof, or to such other place or places as Landlord may from time to time designate in writing to Tenant. If the Lease Term shall begin or terminate on any day except the first day of the month, a prorated monthly rental, based upon a thirty (30) day month, shall be paid for that portion of the month, which falls within the Lease Term.

As to both the Premises and the Building, the respective measurements of floor area are computed in accordance with the BOMA (Building Owners and Managers Association International) American National Standard Z65.1 1980 Method for Measuring Floor Space in Office Buildings, approved July, 1996. Any and all space in the Premises and the Building, which may from time to time be subject to lease by Tenant and all tenants of the Building, respectively, shall be determined by Landlord measuring floor area on a consistent basis throughout the Building. Tenant's Premises contains approximately 2,425 square feet of rentable area.

(b) The Annual Base Rental, as the same may hereafter be adjusted, shall be payable promptly when due without notice or demand therefor and without any abatement, deduction or setoff for any reason whatsoever, except as may be expressly provided in this Lease.

(c) 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 thirty (30) days from the Effective Date, but no later than July 1, 2024, and diligently pursue the issuance of the same. If following the application for all Governmental Approvals in a timely manner, Tenant does not obtain such Governmental Approvals, Tenant may, upon written notice to Landlord given at any time on or before September 1, 2024, terminate this Lease. 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 2 (c) shall expire. Tenant shall be solely responsible for obtaining all Governmental Approvals at its sole cost.

3. Work to be Done by Landlord and Occupancy.

(a) All work of initially preparing the Premises for occupancy by Tenant shall be done by Landlord on terms to be agreed upon with Tenant under a separate "work letter" attached hereto as Exhibit "B" and made a part hereof by reference. The facilities, materials and work to be furnished, installed and performed to the Premises by Landlord as set forth on Exhibit "B" are hereinafter referred to as "T.I. Work". Any alteration or improvement to the Premises which is not included in the T.I. Work and which Tenant requests during the term of this Lease or any extension hereof shall be paid for by Tenant and shall be made according to the provisions of Section 10 hereof, and in no event shall Tenant undertake improvements to any loadbearing internal wall, external wall, or any window or window unit in any exterior wall of the Premises.

(b) The Premises shall be deemed "Ready for Occupancy" on the date on which (i) T.I. Work shall have been substantially completed, and (ii) possession of the Premises is made available to Tenant, and (iii) the Premises may be lawfully occupied by Tenant (evidenced by a temporary or permanent certificate of occupancy). T.I. Work shall be deemed to be substantially completed notwithstanding that minor or insubstantial details of construction, mechanical adjustment or decoration with respect to the Premises remain to be performed, so long as the non-completion thereof does not materially interfere with Tenant's use of the Premises. Tenant shall have sixty days (60) following the Commencement Date to notify the Landlord in writing of any defects in the construction of the Premises and Landlord shall immediately proceed to repair such items.

(c) Landlord anticipates that Premises will be Ready for Occupancy approximately October 1, 2024 ("Anticipated Commencement Date").

(d) If Landlord, except as otherwise herein provided, shall be delayed or hindered in, or prevented from the performance of any act required hereunder by reason of strikes, lockouts, labor troubles, inability to procure materials, failure of power, restrictive governmental laws or regulations, riots, insurrection, war or other reason of a like nature not the fault of Landlord, then performance of such act shall be excused for the period of delay and the period for the performance of any such act shall be extended for a period equivalent to the period of such delay. In the event of any inconsistency between this Paragraph and Exhibit "B", the provisions of this section shall prevail.

4. Operating Cost Adjustment. The Annual Base Rental shall be subject to periodic adjustment at successive annual intervals for increases in Annual Operating Cost after the calendar year 2024 in accordance with the following provisions:

(a) "Base Operating Cost" shall mean Annual Operating Cost (as hereinafter defined) for the calendar year 2024, adjusted to reflect gross up of Annual Operating Costs as if tenants occupy 95% of the rentable space in the Building, including adjustments for any government-mandated closures or reduced occupancy as a result of national or global pandemics. The Base Operating Cost shall also include real property taxes reflecting a fully completed and occupied building. If by the year 2024, the Building and land have not been reassessed, then the fully assessed real property taxes shall be estimated by the Landlord until the next reassessment year at which time the Base Operating Costs will be adjusted to include the actual property taxes for such reassessment year.

(b) The "Adjusted Rental Period" shall mean each successive twelve (12) month period following December 31, 2024.

(c) "Annual Operating Cost" shall mean any and all reasonable costs and expenses paid, incurred or charged by Landlord during an Adjusted Rental Period in connection with the operating, servicing and maintenance of the Building, its equipment and the adjacent walks, drives, landscaped areas, water retention facilities and other improvements which constitute the common areas of the office park in which the Building is located ("Office Park") and the land upon which the same are located, during a calendar year commencing January 1 and ending December 31 (or if the Building is in operation less than a full calendar year, then annualized to a full calendar year) and shall include but shall not be limited to:

i) The amount of real estate taxes, personal property taxes, assessments, state and local taxes or any other governmental tax assessed against the Building and Office Park and all improvements now or hereafter located thereon, including the adjacent walks and landscaped areas and the land upon which the Building and Office Park and walks and landscaped areas are located, offset by any tax refund received by Landlord with respect to the Building and Office Park during an Adjusted Rental Period. If the tax year for real estate taxes shall be changed, then an appropriate adjustment shall be made in computation of the Annual Operating Cost in accordance with sound accounting principles to effectuate the changeover to any new tax year adopted by the taxing authorities.

ii) The reasonable expenses incurred by Landlord in contesting the validity or the amount of the assessed valuation or of any taxes for any year with respect to the Building and Office Park.

iii) Insurance premiums paid by Landlord with respect to the Building and Office Park, including fire or other casualty insurance, rent loss insurance, plate glass insurance and public liability insurance on the Building and Office Park.

iv) The wages paid to all personnel of Landlord below the rank of Property Manager and amounts paid to its independent contractors for personnel whose duties are connected with the day to day or periodic operation, maintenance, repair or security of the Building and Office Park, which shall include related employment taxes and fringe benefits or related expenses imposed on Landlord or its independent contractors pursuant to law.

v) A management fee which shall be a percentage (not to exceed 5%) of the gross monthly rental from the Building and Office Park and shall represent payment for the handling of the renting and operation of the Building and Office Park, the hiring and firing of onsite personnel, and the arranging for the collection of and accounting for rent, the paying of bills, bookkeeping services, the purchase of goods and supplies, the contracting

for maintenance, repairs, and insurance. To provide such management service, Landlord may enter into a contract with such persons, firms or corporations as it may in its discretion determine.

vi) The cost of electricity consumed by lighting fixtures and normal power appliances in all tenant spaces and equipment for lighting the Building and Office Park and operation of the Building and Office Park equipment, services and facilities.

vii) The cost of heating consumed in the operation of the Building and Office Park.

viii) The cost of cooling consumed in the operation of the Building and Office Park.

ix) The water and sewer costs incurred in the operation of the Building and Office Park.

x) The amount expended for maintenance and operation of all elevators and heating and air conditioning equipment in the Building and Office Park.

xi) The amount expended for maintenance and operation of all security systems of the Building and Office Park.

xii) The cost of purchasing or renting all materials including supplies, tools and equipment used in the maintenance, operation or repair of the Building and Office Park, including all sales and excise taxes applicable thereto, and the cost of periodic maintenance and restoration of Building and Office Park common areas, elevators, heating, air conditioning, electrical, plumbing and other utility and equipment systems and Building and Office Park surfaces, including paint, floor and wall coverings, and nonstructural costs incurred by reason of changes in any regulations, rules, requirements, laws, codes, directives or similar pronouncements of any governmental authority with respect to the Building and Office Park.

xiii) The cost of cleaning and janitorial services for the Building and Office Park including all tenant space if paid by Landlord.

xiv) The cost of trash and garbage removal, vermin extinction, and snow, ice and debris removal.

(d) Notwithstanding the foregoing, the Annual Operating Cost shall not include (i) income or franchise taxes or any other taxes imposed upon or measured by Landlord's income or profits (except rent tax as defined in Section 5 hereof), (ii) compensation or other financial benefits (other than the management fee) paid to Landlord's partners or, to Landlord's officers, directors, or stockholders; (iii) costs and expenses, of whatever nature, payable by Landlord which under generally accepted accounting practices would be classified as capital expenses; (iv) the cost of any work or service performed in any instance for any tenant (including the Tenant) at the cost of such tenant; and (v) any expense for which Landlord is reimbursed by Landlord's general contractor based on contractor warranties.

(e) If the Annual Operating Cost for any Adjusted Rental Period shall be higher than the Base Operating Cost, Tenant shall pay to Landlord, as additional rent for such Adjusted Rental Period, an amount equal to Tenant's Pro Rata Share of such increase, which percentage represents the percentage of the rentable square feet in the Building which is occupied by Tenant pursuant to this Lease. (Landlord reserves the right to adjust this percentage from time to time to reflect the actual percentage of the rentable square feet in the building, which is occupied by Tenant pursuant to this Lease.) As soon as practical after January 1st following an Adjusted Rental Period, Landlord shall furnish to Tenant a statement ("Operating Cost Statement") made in accordance with generally accepted accounting principles showing the Annual Operating Cost for the preceding Adjusted Rental Period, and the additional rent, if any, due from Tenant after deducting the estimated Annual Operating Cost rental payments, if any, received by Landlord from Tenant. In the event additional rent is due, Tenant shall pay to Landlord such additional rent within thirty days (30) following the receipt by Tenant of the Operating Cost Statement hereinabove referred to. Based on Landlord's estimate of Annual Operating Cost for the immediately preceding Adjusted Rental Period, delivered to Tenant prior to the commencement of an Adjusted Rental Period, Tenant shall also pay to Landlord as estimated additional rental, in equal monthly installments during the then current Adjusted Rental Period, at the times the Annual Base Rental is payable, an amount equal to the amount of

the additional rental payable under this Section 4 of the preceding Adjusted Rental Period divided by twelve (12), with such payments to be adjusted when the Operating Cost Statement is delivered to Tenant. If the estimated additional rental paid by Tenant for any Adjusted Rental Period exceeds the amount of additional rental payable by Tenant for any Adjusted Rental Period, the amount of monthly rental payments payable by Tenant pursuant to Section 2 for the next succeeding Adjusted Rental Period shall be adjusted according to the amount of additional rental paid under this Section 4 for the preceding Adjusted Rental Period, and any refund to which Tenant may be entitled will be credited against future rents on a monthly basis, or, in the event such refund shall be due for the last year of occupancy by Tenant, paid in cash at the time said statement is delivered. If the Expiration Date occurs on any day other than December 31st, any payment due to Landlord or to Tenant by reason of any increase or decrease in the Annual Operating Cost shall be prorated. Anything herein to the contrary notwithstanding, the amount of annual rental paid by Tenant, shall not be less than the amount specified in Section 2 hereof as Annual Base Rental. Any credit to Tenant which cannot be applied as a result of the immediately preceding sentence, will be credited toward excess rental payments owing in subsequent Adjusted Rental Periods.

(f) Notwithstanding anything in this Section 4, the per year Annual Operating Cost increase shall not exceed five percent (5%) with the exception of increases in real estate taxes, provided that the Base Operating Costs reflect a building that is fully assessed by the local property taxing authority.

5. Rent Tax. In the event that any Federal, State or local law is passed during the Lease Term, or any extension or renewal thereof, requiring the payment of a tax or assessment based on the amount of rent to be paid by Tenant under this Lease, or in any other manner subjecting the rent provided in this Lease to any other form of tax by whatever name it may be designated, such tax shall be the obligation of and shall be in addition to the rent to be paid by Tenant as specified in this Lease.

6. Quiet Enjoyment. Tenant, upon paying rent and observing and performing all the terms, covenants and conditions on Tenant's part to be observed and performed, shall peaceably and quietly have, hold and enjoy the Premises for the Lease Term and any extensions or renewals thereof.

7. Services.

(a) Provided Tenant is not in default hereunder, Landlord agrees to furnish to the Premises during reasonable hours which shall not be less than 8:00 am – 6:00 pm MondayFriday of generally recognized business days ("Building Operating Hours"), subject to the conditions and in accordance with the standards set forth in the Rules and Regulations attached hereto, as may be amended in writing by Landlord from time to time during the term of this Lease and delivered to Tenant, reasonable quantities of electric current for normal lighting and fractional horsepower office machines, including, but not limited to, copiers, personal computers, printers and other computer peripherals, fax machines, etc., hot and cold water for lavatory and drinking purposes, heat and airconditioning required in Landlord's reasonable judgment for the comfortable use and occupation of the Premises, five (5) day per week janitorial service, to the Premises and the Building common areas security service and elevator service by nonattended automatic elevators. All heating and air conditioning costs incurred by Tenant on days other than during Building Operating Hours shall be an additional cost to be borne solely by Tenant at a cost of Ten and 47/100 Dollars ($10.47) per hour per zone paid to Landlord. If Tenant requires or utilizes more water or electrical power than is standard for general office use as reasonably determined by Landlord, Landlord may, at its option, require Tenant to pay, as Additional Rent, the cost, as fairly determined by Landlord, incurred by such extraordinary usage. In addition, Landlord may install separate meter(s) for the Premises, at Tenant's sole expense, and Tenant thereafter shall pay all charges for such extraordinary utility consumption at Landlord's actual cost. Tenant shall cooperate with any conservation practices established by Landlord. If there is any failure, stoppage or interruption thereof, Landlord shall use reasonable diligence to resume services promptly. Landlord shall at all times have reasonable access to all mechanical installations of the Building and Office Park, including but not limited to air conditioning equipment and vents, fans, ventilating and machine rooms and electrical closets.

(b) Landlord reserves the right to interrupt or suspend any such services when necessary, either because of accident or emergency or because of the necessity for repairs, alterations, replacements or improvements. Landlord shall not be liable for any damages or injuries to Tenant or others nor shall there be an abatement of rent arising from the failure by Landlord to furnish such services or from the interruption or suspension of such services and no such failure to furnish such services shall be deemed an actual or constructive eviction of Tenant. Landlord

shall, to the extent possible, give Tenant reasonable notice of any interruption or suspension of such services and Landlord shall use reasonable diligence to restore such services as soon as possible in the event of such failure, interruption or suspension.

8. Use of Premises. Tenant may use the Premises only for general administrative offices and related purposes exclusively serving Tenant's employees and guests and for no other purpose. Tenant shall not create nor allow any nuisance to exist, nor shall Tenant permit any unreasonable noise or odor to emanate from the Premises. Tenant shall not place a load upon any floor of the Premises exceeding the floor load per square foot, which such floor was designed to carry. Tenant shall not use the Premises in any manner which causes or is likely to cause injury to the Building and Office Park or any equipment, facilities or systems therein or which impairs the character, reputation or appearance of the Building and Office Park as a first class office building or which impairs the maintenance, operation and repair of the Building and Office Park or its equipment, facilities or systems or which unreasonably annoys or inconveniences other tenants or occupants of the Building and Office Park or which increases pedestrian traffic in and out of the Premises or the Building and Office Park above a reasonable level. Tenant shall maintain in good condition, and use as intended by Landlord, the equipment and furnishings described as "Tenant's Work" on Exhibit "B" hereto. Tenant shall have access to the Building twentyfour (24) hours per day, seven (7) days per week.

9. Compliance With Laws. In the use and occupancy of the Premises, Landlord and Tenant shall comply with all laws and ordinances including the Americans with Disabilities Act (ADA) and NFPA 101, "Code for Safety to Life" and all valid rules and regulations of the United States, the State of Tennessee, the County of Hamilton, the City of Chattanooga, and any other applicable government or agency having authority.

Neither Landlord or Tenant shall install, use or operate or permit to be installed, used or operated within the Premises or use or operate elsewhere in or about the Building and Office Park, any hazardous substance or material or any substance or material which fails to comply with any and all applicable federal, state or local laws and regulations as now or hereafter in effect. The terms "hazardous substance" or "hazardous material" include without limitation asbestos, fluids containing polychlorinated biphenyls, pesticides or petrochemicals or other toxic substances or materials. Tenant shall permit Landlord and Landlord's agents, environmental consultants and engineers access to the Premises for the purpose of environmental inspections during regular business hours or during other hours either by agreement of the parties or in the event of an environmental emergency. Tenant promptly will furnishLandlord with any notice, which Tenant receives from any governmental authority that Tenant or the Premises are or may be in violation of applicable federal, state or local laws or regulations. Landlord and Tenant shall indemnify, defend and hold harmless the other party from and against all claims, liabilities, losses, damages and costs, foreseen and unforeseen, including without limitation, counsel, engineering and other professional or expert fees which either party may incur by reason ofthe other party's action or nonaction with regard to its obligations under this Section. This Section 9 shall survive the expiration or earlier termination of this Lease. Landlord's or Tenant's failure to abide by the terms of this paragraph shall be restrainable by injunction.

10. Repairs and Alterations by Tenant.

(a) Subject to the provisions herein, Tenant shall, at its expense and under Landlord's supervision, keep the Premises, including without limitation the improvements, fixtures, and machinery and any equipment installed therein by Landlord or Tenant, in good order and repair normal wear and tear and damage by fire or other casualty excepted. In the event that damage or disrepair to the Premises occurs,Tenant shall give reasonable notice thereof to Landlord, and Tenant shall, at its own expense and under Landlord's reasonable supervision, promptly repair or have repaired any damage or injury to the Premises, including without limitation the improvements, fixtures, machinery and any equipment installed therein by Landlord or Tenant, whether caused by the misuse or neglect thereof by Tenant, or by persons permitted on the Premises by Tenant, or by Tenant moving in and out of the Premises or otherwise. If, because of the nature of Tenant's use or occupancy of the Premises, or because of any governmental regulation now in effect or hereafter in effect, any addition, alteration, change repair or other work of any nature to the Premises (other than alterations, changes, repairs or work to the foundation, exterior walls, interior load bearing and/or sheer walls and/or columns and roof) shall be required or ordered or become necessary at any time during the Lease Term, Tenant shall promptly perform same under the reasonable direction of Landlord, but the entire expense thereof, shall be solely the liability of Tenant, and Landlord shall not be called upon to contribute thereto.

(b) Tenant shall make no material alterations, decorations, installations, additions, or improvements in or to the Premises or the equipment therein, without Landlord's prior written consent which consent shall not be unreasonably withheld, conditioned or delayed. In the event that Landlord does give its consent to any nonstructural alterations, decorations, installations, additional or improvements (herein called "Nonstructural Alterations) proposed to be made by Tenant, such Nonstructural Alterations and the materials and furnishings used therein must be in compliance with all applicable laws, ordinances, regulations and building codes. Additionally, such Nonstructural Alterations shall not interfere with Landlord's ability to furnish services to other tenants, provided, however, that if any such Nonstructural Alterations do interfere with or affect Landlord's ability to provide the services in the Premises described in Section 7 hereof, Landlord shall be relieved from such obligation to the extent of such interference. All such work shall be done at such times and in such manner as Landlord may from time to time reasonably approve and shall be done in full compliance with all laws, rules, regulations, and requirements of all governmental bureaus and bodies having jurisdiction thereover. All Nonstructural Alterations (other than communications equipment, quotation devices or equipment leased by Tenant) shall, at the election of the Landlord, become the property of Landlord and shall remain upon and be surrendered with the Premises as a part thereof at the end of the Lease Term, or the prior expiration of this Lease, as the case may be. In the event the Landlord shall notify Tenant at the time the Nonstructural Alterations are installed, then such of the Nonstructural Alterations as the Landlord has so notified Tenant at the time of installation (as well as any communications equipment, quotation devices or equipment leased by Tenant) shall be removed by the Tenantand Tenant shall restore the Premises to the conditions specified in Landlord's notice at the time the Nonstructural Alterations were installed (except with respect to normal wear and tear and with respect to those items which Landlord has elected to retain in the Premises) at Tenant's own cost and expense at or prior to the expiration of the Lease Term. Landlord shall not be liable for any damages caused by any failure of any Building and Office Park facilities or services, including but not limited to the air conditioning and ventilating equipment installed by Landlord, which failure is caused by alterations, installations, and/or additions by Tenant. Tenant shall be obligated to promptly correct any such faulty installation, and upon Tenant's failure to correct same, Landlord may make such correction and charge Tenant for the cost thereof. Such sum due Landlord shall be deemed additional rent and shall be paid by Tenant promptly upon being billed therefor. Tenant shall keep full and accurate records of the cost of any Nonstructural Alterations in and to the Premises made by Tenant and shall, if requested by Landlord, make the same available to Landlord for use in connection with any proceedings to review the assessed valuation of the Building and Office Park or any proceedings to acquire the Building and Office Park for public or quasipublic use.

(c) Tenant shall have the right, on or before the termination of this Lease, to remove any personal property or trade fixtures that are owned or leased by Tenant and are susceptible to being removed, provided: (i) Tenant is not in default under any provisions of this Lease and (ii) Tenant satisfies Landlord in advance that the Building and Office Park and Premises will be repaired at Tenant's expense immediately after such removal, said repairs to be completed no later than the last day of the Lease Term.

This right of removal shall not include the right to remove any plumbing, wiring, floor covering fastened to the floor, wall covering, paneling, builtin's or similar items and shall not include any furnishings or fixtures that were supplied or paid for by Landlord.

(d) No later than the last day of the Lease Term, Tenant shall remove all of Tenant's personal property and repair all injury done by or in connection with the installation or removal of Tenant's personal property and/or trade fixtures in accordance with the provisions of Section 10(c) above. All personal property of Tenant remaining on the Premises after the expiration of the Lease Term shall be deemed conclusively abandoned and may be removed by Landlord, and Tenant shall reimburse Landlord for the cost of removing the same.

(e) In conducting any work of any nature in, on, to or about the Premises, Tenant shall use only contractors or workmen approved by Landlord (which approval shall not be unreasonably withheld, conditioned or delayed), and Tenant shall promptly pay and discharge any and all liens or other charges arising out of or in connection with the performance of any act required of or permitted Tenant hereunder, and Tenant shall keep the Premises free and clear from any and all such liens or charges and any liens and charges shall exist only against the leasehold estate of Tenant and not against the fee. Additionally, Tenant agrees to indemnify and hold Landlord harmless from and against any and all losses, costs, damages or liabilities resulting from or attributable to any liens

or claims of lien for such work and Tenant shall remove any such lien or claim of lien promptly upon notice of such lien or claim of lien.

(f) In the performance of any acts required of or permitted Tenant hereunder, Tenant shall obey and comply with all lawful requirements, rules, regulations and ordinances of all legally constituted authorities existing at any time during the continuance of such performance which in any way affects the Premises by Tenant. Such compliance shall include compliance by Tenant with the requirements of the Occupational Safety and Health Act and all amendments thereto, as the same applies to Tenant's use of the Premises.

11. Structural Repairs by Landlord. Subject to the provisions of Sections 16 (Destruction of Premises) and 18 (Condemnation), Landlord shall make all necessary repairs to the foundation, exterior walls, interior load bearing and/or sheer walls, columns, roof, structural parts, common areas, elevators, heating, air conditioning, electrical, plumbing and other utility systems of the Building(exclusive of any such systems installed for the sole and exclusive benefit of Tenant), and with the Premises to fixtures appertaining to utility systems, provided such interior repairs are not caused by Tenant's gross negligence or willful misconduct. Landlord shall have the right, but not the duty, to enter the Premises during any reasonable hours, upon twenty four (24) hours prior written notice, in order to examine the Premises, or to make such repairs, at its expense, as Landlord may deem necessary for the safety of, comfortable habitation in, or preservation of, the Premises or of the Building.

12. Allowance and Liability for Alterations. Except as provided in this Lease to the contrary, there shall be no allowance to Tenant for a diminution of rental value and no liability of Landlord to Tenant by reason of inconvenience, annoyance or injury to business arising from Landlord, Tenant or others making any repairs, alterations, additions or improvements in or to any portion of the Premises or of the Building and Office Park or in or to fixtures or other appurtenances thereof, or machines or equipment located therein unless such diminution or liability is caused by Landlord's gross negligence or willful misconduct.

13. Liability, Indemnification and Insurance.

(a) Unless caused by Landlord's gross negligence or willful misconduct, Tenant covenants and agrees that Landlord shall not be liable to Tenant for any injury to or death of any person or persons or for any loss or damage to any property of Tenant, or any person claiming through Tenant, arising out of any accident or occurrence in the Building and Office Park, including, without limiting the generality of the foregoing, (i) loss or damage occasioned by theft, or (ii) injury, death, loss or damage (A) caused by the Premises or other portions of the Building and Office Park being out of repair, or (B) caused by any defect in or failure of equipment, pipes, or wiring or (C) caused by broken glass, or (D) caused by backing up of drains, or (E) caused by gas, water, steam, electricity, or oil leaking, escaping or flowing into the Premises or (F) caused by fire, smoke, earthquakes or sonic booms, or (G) caused by the acts or omissions of other tenants located in the Building and Office Park.

(b) Tenant does hereby agree to indemnify and save Landlord harmless from any against any and all liability for any injury to or death of any person or persons or loss or damage to property occurring in the Premises in any way arising out of or connected with the condition, use or occupancy of the Premises, or in any way arising out of the activities of the Tenant, its agents and employees in the Premises and from all costs, expenses and liabilities, including but not limited to reasonable attorney's fees, incurred by Landlord in connection therewith excepting, however, liability caused by Landlord's gross negligence or willful misconduct.

(c) Tenant, at Tenant's expense, shall procure and maintain during the life of this Lease, liability insurance with limits of not less than $1,000,000 per person and $3,000,000 per accident for personal injury including death, and $1,000,000 property damage. The policy or policies shall be issued by a company or companies licensed to do business in Tennessee, shall be in form acceptable to Landlord, shall name Landlord as an additional insured and shall contain a provision that the coverage may not be canceled without first giving Landlord not less than thirty (30) days prior written notice. Duplicate policies or certificates of all such insurance shall be delivered to Landlord not less than five (5) days prior to the effective date of each. Landlord, likewise, at Landlord's expense shall procure and maintain during the term of this Lease public liability insurance with limits not less than $1,000,000 per person and $3,000,000 per accident for personal injury including death and $1,000,000 property damage.

(d) Landlord shall insure the Building and Office Park against damage by fire and other perils insurable at normal rates, for 100% of the replacement cost of the Building, exclusive of foundations and architectural and engineering fees, which will provide Landlord with coverage for the full replacement cost of Tenant's improvements, and Landlord shall maintain such insurance throughout the Lease Term. Tenant shall insure with companies licensed to do business in Tennessee and of a Best AA rating or higher, all of its property in the Premises and all leasehold improvements to the Premises against damage by fire, including extended coverage for full replacement cost and Tenant shall maintain such insurance throughout the Lease Term. Tenant from time to time, as reasonably requested by Landlord, but no less frequently than annually, will furnish Landlord with certificates of insurance evidencing the required coverage and naming Landlord as an additional insured with a standard form of loss payable endorsement.

(e) Waiver of Subrogation. Mutual Waiver. All property damage insurance policies required of each of the parties hereunder shall contain appropriate clauses pursuant to which the respective insurance carriers shall waive all rights of subrogation with respect to losses payable under such policies; and each party waives any claims against the other party for any damage to its property. Tenant and Landlord each hereby release and relieve the other, and waive their entire right of recovery against the other, for direct or consequential loss or damage arising out of or incident to the perils covered by property insurance maintained by such party, or required to be maintained by such party under this Lease, whether due to the negligence of Landlord or Tenant or their agents, employees, contractors and/or invitees. If necessary, all property insurance policies required under this Lease shall be endorsed to so provide.

14. Performance by Tenant; Late Charges.

In the event Tenant fails to pay any installment of Base Rent when due, or any payment of Additional Rent, said delinquent installment or payment shall bear interest at the rate of the lesser of twelve percent (12%) per annum or the maximum nonusurious interest rate permissible by law from the date such payment was due until paid. Tenant covenants to pay any such sums, and Landlord shall have (in addition to any other right or remedy of Landlord) the same rights and remedies in the event of nonpayment thereof by Tenant as are set forth in Paragraph 17 hereof. Tenant hereby acknowledges that in addition to lost interest, the late payment by Tenant to Landlord of Base Rent, or any Additional Rent, or other sums due hereunder, will cause Landlord to incur other costs not contemplated in this Lease, the exact amount of which is extremely difficult and impractical to ascertain. Such other costs include, but are not limited to, processing and administrative and accounting costs. Accordingly, if any installment of Base Rent or any other sum due from Tenant shall not be received by Landlord within ten (10) days after such amount shall be due, Tenant shall also pay to Landlord an additional sum equal to the greater of One Hundred Dollars ($100.00) or five percent (5%) of the amount overdue as a late charge for every month or portion thereof that amount remains unpaid. The parties hereby agree that (a) such late charge represents a fair and reasonable estimate of the costs Landlord will incur in processing each delinquent payment by Tenant, (b) that such late charge shall be paid to Landlord as liquidated damages for each delinquent payment, and (c) that the payment of late charges and the payment of interest are distinct and separate from one another in that the payment of interest is to compensate Landlord for the use of Landlord's money by Tenant, while the payment of late charges is to compensate Landlord for the additional administrative expenses incurred by Landlord in handling and processing delinquent payments.

15. Rules and Regulations.

(a) So long as all rules and regulations are equally applied to all tenants of the Building, Tenant, Tenant's agents, employees,invitees and visitors shall observe and comply with the rules and regulations attached hereto and made a part hereof as Exhibit "C", and such further reasonable rules and regulations as Landlord may prescribe on written notice to Tenant, for the safety, care and cleanliness of the Building and Office Park, and the comfort, quietness and convenience of other occupants of the Building and Office Park. Such rules and regulations may be changed or amended by Landlord in its reasonable judgment at any time and from time to time. Such rules and regulations shall not amend or modify the terms and conditions of this Lease and, any conflict between such rules and regulations and the provisions of this Lease, shall be controlled by the provisions of this Lease.

(b) Landlord shall incur no liability, and Tenant shall not be relieved of any obligation under this Lease because of any interference or disturbance of Tenant's use and occupancy of the Premises, or breach of or

noncompliance with any rule or regulation, or amendment or addition thereto, by third persons, including other tenants of the Building and Office Park. Landlord, however, will use best efforts to protect Tenant from said interference, disturbance, breach, or noncompliance.

(c) Tenant shall not, except to designate Tenant's business address (and then only in a conventional manner and without emphasis or display), use the name "The Pointe Centre" or any simulation or abbreviation of such name for any purpose whatsoever.

16. Destruction of Premises.

(a) If during the Lease Term, the Building and Office Park is damaged by fire or any other cause, the following provisions shall apply:

i) If the damage is to such extent that the cost of restoration, as estimated by Landlord, will equal or exceed 50% of the replacement value of the Building(exclusive of foundations) in its condition just prior to the occurrence of the damage, Landlord may, no later than sixty (60) days following the damage, give Tenant a notice stating that it elects to terminate this Lease. If such notice shall be given: (A) this Lease shall terminateas of the date of casualty; (B) Tenant shall surrender possession of the Premises within a reasonable time thereafter; and (C) the rent and additional rent shall be apportioned as of the date of casualty and any rent paid for any period beyond said date shall be repaid to Tenant.

ii) If the cost of restoration, as estimated by Landlord, shall amount to less than 30% of said replacement value of the Building, or if the cost of restoration, as estimated by Landlord, equals or exceeds 50% of the replacement value of the Building but Landlord does not elect to terminate this Lease pursuant to the provisions of Section 16(a)(i) above, and, in either case the restoration can be completed within one hundred twenty (120) days after the date of casualty, Landlord shall restore the Building within such time period, subject to delays beyond Landlord's control and reasonable delays in the making of insurance adjustments by Landlord, and Tenant shall not have the right to terminate this Lease. If Landlord elects to restore but the Building cannot be restored within one hundred twenty (120) days then Tenant shall have the right to terminate this Lease by written notice given to Landlord within thirty (30) days after receipt of written notice from Landlord that the Building cannot be restored within such time period. If such notice shall be given: (A) this Lease shall terminate as of the date of casualty; (B) Tenant shall surrender possession of the Premises within thirty (30) days thereafter; and (C) the rent and additional rent shall be apportioned as of the date of casualty and any rent paid for any period beyond said date shall be repaid to Tenant. If Tenant does not terminate the Landlord shall restore.

(b) If the Premises are damaged by fire or other casualty insurable under a standard fire and extended coverage policy and if Landlord does not terminate this Lease under Section 16(a)(i) above, then Landlord shall restore that portion of the Premises so damaged. Landlord shall pay for the cost of restoring Tenant's improvements. Such restoration shall be with reasonable promptness, subject to delays beyond Landlord's control and delays in the making of insurance adjustments by Landlord, and Tenant shall not have the right to terminate this Lease. Tenant shall restore its trade fixtures, improvements or other property of Tenant.

(c) In any case in which Tenant's use of the Premises is affected by any damage to the Building or the Premises and irrespective of whether Landlord elects to terminate this Lease or restore the Building, there shall be a pro rata adjustment or abatement in rent during the period for which and to the extent the Premises are not accessible and not reasonably usable for the purposes for which they are leased based upon the square footage of the Premises which is not accessible and not reasonably usable. The words "restoration" and "restore" as used in this section shall include repairs.

(d) To the extent permitted by law, and not withstanding anything to the contrary in this Lease, Landlord and Tenant, on behalf of themselves and all parties claiming under them, hereby release and discharge each other from all loss, damage, claim or liability arising from damage to property of the other party caused by fire or other hazard ordinarily covered by fire and extended coverage insurance policies; and, notwithstanding the provisions of Sections 10, 11 and 13 hereof, in the event of such loss or damage to the Building and Office Park, the Premises and/or any contents of either, each party shall obtain for each policy of such party's insurance, provisions permitting waiver of any claim against the other party for loss or damage within the scope of the insurance.

17. Defaults and Remedies.

(a) Events of Default: The occurrence of any of the events described in subsections (i) through (iv), inclusive, of this Section 17(a), shall be and constitute an Event of Default under this agreement.

i) Failure by Tenant to pay in full any rental or other sum payable hereunder within ten (10) days of the date such payment is due.

ii) Default by Tenant in the observance or performance of any of the terms, covenants, agreements or conditions contained in this Lease, other than as specified in subsection (i) of this Section 17(a), for a period of thirty (30) days after notice thereof to Tenant by Landlord. Provided, however, that if such default cannot be cured within such thirty (30) day period and Tenant has commenced actions to cure such default within such thirty (30) day period, and is diligently proceeding to cure such default, then Tenant shall be granted such reasonable additional time required to cure the default.

iii) Filing by Tenant, or any guarantor of Tenant's obligations hereunder, of a voluntary petition in bankruptcy or a voluntary petition or answer seeking reorganization, arrangement, or readjustment of the debts of Tenant or for any other relief under the Bankruptcy Act, as amended, or under any other insolvency act, law, rule or regulation, State or Federal, now or hereafter existing, or any action by Tenant indicating consent to, approval of, or acquiescence in, and any such petition or proceeding, the filing of any involuntary petition in bankruptcy against Tenant, the application by Tenant for, or appointment by Tenant's consent or acquiescence of, a receiver or trustee of Tenant, or for all or a substantial part of the property of Tenant; the making by Tenant of any general assignment for the benefit of creditors of Tenant; or the inability of Tenant, or the admission of Tenant of the inability thereof, to pay the debts of Tenant as such mature.

iv) The insolvency of Tenant or of any guarantor of Tenant's obligations hereunder.

(b) Remedies: Whenever any Event of Default shall have happened and be continuing, Landlord may, to the extent permitted by law, take any one or more of the remedial steps described in subsections (i) through (v), inclusive, of this Section 17(b), subject, however, to the right, title and interest of any lender of the Landlord:

i) Landlord may, at its option, declare all installments of Annual Base Rental as adjusted at the time of default, and all additional rent for the remainder of the Lease Term, to be immediately due and payable, whereupon the same shall become immediately due and payable. Any installment of rent or any other charge or money obligation herein required to be paid by Tenant which is not paid when due shall bear interest at the highest lawful contract rate permitted under applicable law from the due date until paid, and Landlord may treat any such charge or money obligations as additional rent due hereunder.

ii) Landlord may reenter and take possession of the Premises without terminating this Lease, and sublease in their entirety the same for the account of Tenant, holding Tenant liable for the difference in the rent and other amounts actually paid by such sub-lessee in such subletting and the rents and other amounts payable by Tenant hereunder.

iii) Landlord may terminate this Lease, remove Tenants from possession of the Premises and use reasonable efforts to lease the same to another for the account of Tenant, holding Tenant liable for all rent, unamortized tenant improvements, commissions and other amounts payable by Tenant hereunder.

iv) Upon Landlord's commencement of the exercise of the remedies set forth in the foregoing subsections 17(b)(ii) or 17(b)(iii), Tenant specifically waives all right to vacate the Premises immediately without the necessity for any further notice or the expiration of any time period, both of which are hereby specifically waived by Tenant.

v) Landlord may take whatever action at law or in equity may appear necessary or desirable to collect the rent and other amounts then due and thereafter to become due or to enforce performance and observance of any obligation, agreement, or covenant of Tenant under this agreement, and in connection with such actions, to recover any or all damages accruing to Landlord for Tenant's violation or breach of this Lease.

(c) Application of Funds: If any statute or rule of law shall validly limit the amount of any final damages described in Section 17(b) to less than the amount agreed upon, Landlord shall be entitled to the maximum amount allowable under such statute or rule of law. All rents and other income derived from operation of the improvements by Landlord, to the extent such are not paid and applied by any sub-lessee or new tenant of the Premises, shall be applied first, to the payment and accrual of taxes; second, to the cost of operating the Premises; third, to the cost of administration and collection of rents by Landlord; and fourth, to the payment of rent due and owing Landlord hereunder. Tenant shall be liable to Landlord for the deficiency, if any, between Tenant's rent hereunder, and the amounts applied by Landlord to said rents in the manner hereby authorized.

(d) No Remedy Exclusive: No remedy herein conferred upon or reserved to Landlord is intended to be exclusive of any other available remedy or remedies, but each and every such remedy shall be cumulative, and shall be in addition to every other remedy given under this agreement or now or hereafter existing at law or in equity or by statute. No delay or omission by Landlord to exercise any right or power accruing upon any default of Tenant shall impair any such right or power or shall be construed to be a waiver thereof, but any such right or power may be deemed expedient. In order to entitle Landlord to exercise any remedy reserved to it in this Section 17, Landlord shall not be required to give any notice other than such notice as expressly required by this agreement.

(e) In the event of any dispute between the parties with respect to this Lease the prevailing party shall be entitled to recover reasonable attorney's fees and expenses from the other party.

18. Condemnation. If the whole of the Premises shall be taken for any public or quasipublic use, under any statue or by right of eminent domain or private purchase in lieu thereof by a public body vested with power of eminent domain, then, when possession shall be taken thereunder of the Premises, the term herein demised and all the rights of Tenant hereunder shall immediately terminate. If only a part of the Premises shall be so condemned or taken, then, when possession shall be taken thereunder of a part of the Premises, a portion of the Annual Base Rental and additional rent hereunder shall be abated and apportioned according to the square footage of the Premises so condemned or taken. If only a part of the Building shall be so condemned or taken, and the Premises, or any substantial part of either, in Landlord's reasonable judgment requires substantial reconstruction or is no longer economically suitable for rental (whether or not the Premises be affected), then Landlord may, at Landlord's option, terminate this Lease and the term herein demised and all rights of Tenant hereunder shall terminate by Landlord notifying Tenant in writing of such termination within sixty (60) days following the date on which Landlord shall have received notice of vesting of title in the condemning authority, such termination to be effective on the date specified in such notice of Landlord, which date shall beat least one hundred twenty (120) days after the date of such notice. If such partial condemnation or taking shall deprive Tenant of access to the Premises, and Landlord shall not have provided or undertaken steps to provide other means of access thereto, or if such partial condemnation or taking reduces the area of the Premises occupied by Tenant by more than 20%, Tenant may, at Tenant's option, by delivery of written notice to Landlord within sixty (60) days following the date on which Tenant shall have received notice of vesting of title, terminate this Lease,the term herein demised, and all right of Tenant hereunder. Such termination is to be effective on the date specified in such notice, but noearlier than one hundred twenty (120) daysafter the date of such notice. If neither Landlord nor Tenant elects to terminate this Lease as provided above, this Lease shall be and remain unaffected by such condemnation or taking, except that the Annual Base Rental and additional rental shall be abated to the extent, if any, as provided above. Subject to the prior rights of any mortgagee of the Building, if only a part of the Premises shall be so condemned or taken, and this Lease is not terminated as provided above, Landlord will, with reasonable diligence and at its expense, restore the remaining portion of the Premises as nearly as practicable to the same condition as existed prior to such condemnation (and the interest which Tenant may have or claim to have in any award resulting from any such condemnation or taking shall be limited to the unamortized value of any permanent improvements to the structure of the Building paid for by Tenant, and any claim for furniture or fixtures or Tenant's leasehold estate). In the event of termination pursuant to the provisions of this Section 18, the rent shall be adjusted as of the time of such termination, and any rent paid for any period thereafter shall be refunded to Tenant.

19. Assignment and Subletting. Tenant shall not assign or transfer this Lease or any part thereof, or any interest therein, or sublet the Premises or any part thereof, without first obtaining Landlord's prior written consent which consent shall not be unreasonably withheld, conditioned or delayed. Landlord shall respond to Tenant's written request regarding assignment or subletting within ten (10) days of receipt of such request. Such assignment

shall in no way relieve Tenant from any obligations hereunder for the payment of rents or the performance of the conditions, covenants and provisions of this Lease. In no event shall Tenant assign or sublet the leased premises for any terms, conditions and covenants other than those contained herein. Provided, however, that Tenant shall have the right to set the rental to be paid by a subtenant or assignee and to set the term of any assignment or sublease so long as the term of the sublease or assignment expires on or before the expiration or earlier termination of the Lease. In the event Tenant obtains from a subtenant or assignee rental which is greater than the Annual Base Rental being paid to Landlord, Landlord shall be entitled to one hundred percent (100%) of the difference between the amount of Annual Base Rental being paid to Landlord by Tenant and the amount of rental being paid by any subtenant or assignee to Tenant. No court or officer thereof, nor any receiver or trustee in bankruptcy or in any state insolvency proceeding shall acquire any interest in this Lease by operation of law or otherwise. Any of the following transactions will be deemed to be an assignment of this Lease within the meaning of this Section 19 except for (i) a transfer as a result of the death of a shareholder of a corporate tenant or of a limited partner of a partnership tenant, or (ii) a transfer of the equity ownership of any corporation or partnership whose equity securities are registered under this Securities Act of 1934:

(a) A transfer by operation of law or otherwise, except as set forth above, of Tenant's interest in this Lease; or

(b) A transfer of any percentage interest in Tenant (whether stock, partnership interest, or otherwise) in a single transaction or a series of transactions, which over the term of the Lease aggregates to fifty percent (50%) or more of the ownership interest in the Tenant as in effect on the date that Tenant executes this Lease.

20. Maintenance of Food and Drink Machines. Tenant shall not have the right to maintain food or drink coinoperated vending machines within the Premises without the prior written consent of Landlord. Tenant may provide coffee, soft drinks and similar items for its employees and install the equipment therefor.

21. Security Deposit. As security for the prompt and punctual performance of all obligations required to be performed hereunder by Tenant, Tenant shall deposit with Landlord on or before "lease execution, the sum of $4,649.92, representing Annual Base Rental for one month. Upon the occurrence of an Event of Default on the part of Tenant, Landlord, at its sole option, may utilize such deposit to offset, either in whole or in part, any obligations of Tenant hereunder. In the event that the Lease Term expires without all of the security deposit having been used by Landlord pursuant to the provisions of this Section, the remaining balance of the security deposit will be returned by Landlord to Tenant within thirty (30) days after the expiration of the Lease Term, without any interest thereon. Tenant expressly acknowledges that Tenant will not hold any lender of the Landlord liable for the return of all or any part of the security deposit unless the security deposit is escrowed with such lender.

22. Financial Statements. From time to time during the Lease Term, Landlord may request that Tenant provide detailed financial statements (including income statements, balance sheets, cash flow statements, etc.) which have been certified as correct by an authorized officer or manager of Tenant. Tenant shall provide such financial statements within ten (10) days of request by Landlord. Landlord shall not disclose such confidential information to any person or entity other than Tenant, Landlord, Landlord's lenders and prospective purchasers or as may be required in any statement filed with the Security Exchange Commission, Internal Revenue Service or other governmental agency; and as may be required pursuant to subpoena, judicial process or any applicable governmental authority, rule, regulation, code or law.

Transfer of Tenant. Landlord reserves the right, at its option, to transfer and remove Tenant from the Premises to any other available Building and Office Park space of substantially equal size and area and at the same rental as is set forth in this Lease. The Landlord shall bear the expense of such removal as well as the expense of any renovations or alterations necessary to make the new space substantially conform in layout and appointment with the Premises.

23. Surrender and Holding Over. Tenant shall surrender the Premises at the expiration of the term hereof or any extension thereof, or upon other termination of this Lease, in as good condition as received, ordinary wear and tear and damage by fire or other insurance casualty excepted. Tenant, at its expense, promptly will remove all of Tenant's property from the Premises. If Tenant shall default in so surrendering the Premises, Tenant's occupancy subsequent to such expiration or termination shall be deemed to be that of a Tenant at will, and in no event from

month to month or from year to year, but Tenant also shall be subject to all of other terms, covenants and conditions of this Lease, provided that Annual Base Rental during such holdover period will be at the rate of one hundred fifty percent (150%) of the rate in effect during the expired term, and provided further that no extension or renewal of this Lease shall be deemed to have occurred by such holding over.

24. Mortgage Financing.

(a) This Lease is and shall be, at the option of a first mortgagee of the Building, subject and subordinate to any first mortgage or deed of trust (collectively, "mortgage" or "mortgages") which now affects the land or the Building, and this Lease shall be subject and subordinate to any and to all renewals, modifications, consolidations, replacements and extensions thereof. Although this subordination provision shall be deemed for all purposes to be automatic and effective without any further instrument delivered on the part of Tenant, Tenant shall, upon the request of Landlord and/or the holder of any mortgage on the Premises, execute and deliver such instruments as may be required by Landlord and such holder to make this Lease either superior or subordinate to any mortgages now or hereafter placed upon Landlord's interest in the Premises or future additions thereto. Landlord shall obtain a covenant in any such subordination agreement that this Lease shall be recognized by the mortgagee and that the rights of Tenant hereunder shall remain in full force and effect during the term of this Lease and any extensions thereof, notwithstanding any default of mortgagors with respect to said mortgages or any foreclosure thereof, so long as Tenant shall perform all of Tenant's covenants hereunder. Tenant hereby attorns to any purchaser at a foreclosure sale or sale in lieu of foreclosure, and agrees to execute all agreements required by any such purchaser affirming such attornment. Nothing contained in this agreement shall be construed as placing any limitation upon Landlord's right to sell, mortgage, assign or in any manner convey an interest, in part or in whole, in either the land or the Building, or both.

(b) If any lending institution with which Landlord is negotiating interim or long term financing for the Buildingrequest changes in this Lease as a condition of such financingTenant shall execute documents required to make such reasonable changes as may be required by the lender so long as the changes do not have a material negative impact to Tenant.Notwithstanding anything contained herein to the contrary, Tenant shall not be required to agree, to any modification to this Lease relating to Annual Base Rent, T.I. Work, the size of location of the Premises, or the duration or the Commencement Date of the Lease Term.

(c) Tenant shall give prompt written notice, in the manner hereinafter provided, to any mortgagee of which Tenant has notice, of any default of Landlord hereunder, and Tenant shall allow such mortgagee a reasonable length of time (in any event, not less thanthirty (30) days from the date of such notice), in which to cure any such default. Any such notice shall be sent to the Mortgage Loan Department of any such mortgagee at its home office address.

25. Signs. Tenant shall not cause or permit any sign or other object to be placed on or affixed to any part of the Building and Office Park, unless (i) it is contemplated by T.I. Work as described on Exhibit "B", or (ii) Landlord's prior written consent is obtained. Landlord, in addition to all other remedies, shall be entitled to remove any sign not allowed under this Section.

Landlord shall provide tenant at Landlord's sole cost and expense with Tenant's name and suite number on the directory board in the lobby of the building and an entry door signage on Tenant's suite. Landlord shall also provide tenant with signage on a directory at the entrance to the parking lot and entry door signage on Tenant's suite.

26. Broker. Landlord and Tenant agree that no broker other than David Melton with Pointe Commercial Real Estate has been involved in the negotiation or consummation of this Lease. Landlord and Tenant each will hold the other harmless against any and all claims for a brokerage commission or other compensation arising out of any discussions or negotiations with respect to this Lease, other than with respect to the broker set forth above, which by separate agreement must acknowledge the terms of payment of its commission.

27. Access to Premises. Landlord and its agents shall have the right to enter the Premises at all reasonable times upon twenty four hours prior written notice (i) to examine the Premises, (ii) to perform any obligation for which Landlord is responsible hereunder, or (iii) to exhibit the Premises topotential lenders or purchasers, and, during the last six (6) months of the term, to potential tenants.

28. Landlord's Lien. Tenant hereby pledges, assigns and grants a security interest to Landlord in all of the furniture, fixtures and other personal property of Tenant, which are, or may be put in, on or about the Premises as security for the payment of rent herein reserved. The lien hereby created may be enforced by distress, foreclosure or otherwise, at the election of Landlord.

29. Parking. All parking will be free of charge and Tenant shall have access to all parking spaces twentyfour (24) hours per day. The Building shall have 4.5 parking spaces per 1,000 square feet of gross leaseable floor area.

30. Termination Option. Tenant shall have a "one time" right to terminate the lease at the end of the thirty-ninth (39th) month or at the end of the fifty first (51st) month by providing Landlord an advance written notice no less than 60 days prior to the termination date ("Notice").

31. Exhibits. The exhibits referred to in this Lease and any exhibit not referred to herein but initialed by both parties hereto and attached to this Lease, shall be a part hereof as fully as if set forth in their entirety herein.

32. Other Charges. All charges permitted by the Lease (other than T.I. Work) against Tenant by Landlord for work done on the Premises by order of Tenant or otherwise accruing under this Lease shall be treated as rent due hereunder for the purposes of determining whether Tenant has committed an event of default and shall be payable as such unless a specific date for payment is otherwise stated. The requirements for paying all other changes shall be identical to the requirements for paying Annual Base Rental.

33. Notices. All notices herein provided shall be in writing and shall be deemed given when sent either by (i) Registered or Certified Mail, Postage Prepaid, Return Receipt Requested, and deposited in the mail, (ii) when sent by Federal Express, or (iii) by electronic transmission in either case addressed to Landlord and Tenant as follows:

LANDLORD:	1200 Pointe Centre Partners, GP 1209 Pointe Centre Drive, Suite 101 Chattanooga, TN 37421 Attn: Penny Manis pmanis@pointecentre.com
TENANT:	Shalom Hospice of Greater Knoxville, LLC 2302 Quentin Road Brooklyn, NY 11229 Attn: Ariel Joudai ajoudai@affinityhealthmanagement.com

Either party may change its address for purposes of notice, by written notice given in like manner at least seven (7) days before the effective date of such change of address.

34. No Waiver. No failure of Landlord to exercise any power given Landlord hereunder or to insist upon strict compliance by Tenant with its obligations hereunder, and no custom or practice of the parties at variance with the terms hereof shall constitute a waiver of Landlord's right to demand exact compliance with the terms of this Lease.

35. Waiver of Notice. Tenant waives any and all notices required by law, other than such notice as may be specifically required in this Lease.

36. Entire Agreement. This Lease and any addendum or exhibit now or hereafter attached hereto contain the entire agreement between parties, and all prior written verbal understandings and agreements are merged herein. This Lease may not be altered, changed or amended, except by an instrument in writing signed by both parties hereto.

37. Partial Invalidity. If any term or condition of this Lease or the application thereof to any person or event shall to any extent be invalid and unenforceable, the remainder of this Lease and the application of such term,

covenant or condition to persons or events other than those to which it is held invalid or unenforceable shall not be affected and each term, covenant and condition of this Lease shall be valid and be enforced to the fullest extent permitted by law.

38. Captions, Construction of Words. The captions in this Lease are for convenience only and are not intended to limit or amplify the terms and provisions of this Lease. Whenever the context permits or requires, words in the singular may be regarded as in the plural and viceversa and personal pronouns may be read as masculine, feminine or neuter.

39. Landlord's Exculpatory Clause. The term "Landlord" as used in this Lease means only the fee simple owner or ground lessee for the time being of the land so that in the event of any sale of sales of such land, or assignment, transfer, or other conveyance of Landlord's rights under this Lease, the Landlord shall be and hereby is entirely freed from and relieved of all covenants and obligations of Landlord hereunder, and it shall be deemed and construed, without further agreement between the parties or their successors in interest, or between the parties and the purchaser at any such sale, or the successor to the Landlord by reason under this Lease, that such purchaser or successor has assumed and agreed to carry out any and all covenants and obligations of the Landlord hereunder.

If the Landlord or any successor in interest or assignee shall be an individual, joint venture, tenancy in common, firm or partnership, general or limited, or corporation, it is specifically understood and agreed that there shall be no personal liability on such individual or the members of the joint venture, tenancy in common, firm, limited or general partnership or corporation, with respect to any of the covenants or conditions of this Lease, and the Tenant shall look solely to the Landlord's equity in the fee simple estate on which the Building and Office Park has been constructed for the satisfaction of the remedies of the Tenant in the event of a breach by the Landlord of any of the terms, covenants and conditions of this Lease to be performed by the Landlord, it being the intent hereof that the Landlord shall have no personal liability of any nature whatsoever.

Notwithstanding the provisions of Section 24, Tenant expressly agrees that the lender of the Landlord shall not be held subject to any liability or obligation to Tenant under this Lease or as a result of foreclosure or otherwise; and, in such event, Landlord's lender shall be subject only to those liabilities or obligations arising subsequent to the date such lender obtains title to the Premises.

40. Documentation; Right to Cure. Tenant does covenant and agree to execute and deliver to Landlord, within ten (10) business days from date of request, such supplemental documents as may be required by Landlord or other lender of the Landlord in connection with this Lease Agreement, including estoppel certificates in such form as may be required by Landlord, which certificates may include some information as to any modifications of this Lease, dates of commencement of term and the termination date of this Lease, and whether or not Landlord is in default hereunder. Any such certificate may be relied upon by any lender or prospective lender of the Landlord, or any assignee or prospective assignee of any lender thereof. If Tenant fails or refuses to furnish such certificate within the time provided, it will be conclusively presumed that this Lease is in full force and effect in accordance with its terms and the Landlord is not in default.

Tenant agrees to give any lender of the Landlord and/or trust deed holder, by certified mail, a copy of any notice of default served upon the Landlord, provided that prior to such notice Tenant has been notified in writing (by way of notice of assignment of rents and leases, or otherwise) of the address of such lender and/or trust deed holder. Tenant further agrees that if Landlord shall have failed to cure such default as required by the terms of the Lease, then the lender and/or trust deed holder shall have the same right to cure any such default within the time period afforded the Landlord after receipt of notice or, if such default cannot be cured within that time, then within such additional time as may be necessary if within such period of time the lender and/or trust deed holder has commenced and is diligently pursuing the remedies necessary to cure such default (including, but not limited to, commencement of foreclosure proceedings if necessary to effect such cure), in which event this Lease shall not be terminated while such remedies are being so diligently pursued.

41. Joint and Several Liability. If this Lease is executed by more than one party constituting the Tenant, all such parties shall be jointly and severally liable for the payment and performance on all obligations of the Tenant hereunder.

42. Governing Law. The Lease shall be governed by, and construed in accordance with, the laws of the State of Tennessee, which are applicable to contracts executed wholly within that state.

43. Successors and Assigns. Except as otherwise expressly provided in this Lease, the obligations of this Lease shall bind and benefit the successors and assigns of the parties hereto.

44. Time. Time is of the essence of this Lease and whenever a certain day is stated for payment or performance of any obligation of Tenant or Landlord, the same enters into and becomes a part of the consideration hereof.

45. Counterparts. This Lease may be executed in multiple counterparts, each of which will be considered an original hereof.

46. USA Patriot Act Compliance. Tenant represents to Landlord, and Landlord represents to Tenant, that the representing party is not (and such party is not engaged in this transaction on behalf of) a person or entity with which either party is prohibited from doing business pursuant to any law, regulation or executive order pertaining to national security ("Anti-Terrorism Laws") and; such party has not violated and, to the best of such party's knowledge it is not under investigation for, the violation of any Laws pertaining to money laundering, as those Laws are more particularly described below.

"Anti-Terrorism Laws", as referenced above, shall specifically include, but shall not limited to, the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and obstruct Terrorism Act of 2001, Pub. L. No. 107-56 (aka, the USA Patriot Act); Executive Order 13224; the Bank Secrecy Act, 31 U.S.C. Section 5311 et. seq.; the Trading with the Enemy Act, 50 U.S.C. App. Section 1 et. seq.; the International Emergency Economic Powers Act, 50 U.S.C. Section 1701 et. seq.; sanctions and regulations promulgated pursuant thereto by the Office of Foreign Assets Control ("OFAC"), as well as laws related to the prevention and detection of money laundering in 18 U.S.C Sections 1956 and 1957.

47. Attachments.

Exhibit "A" – Floor Plans
Exhibit "B" – Work Letter
Exhibit "C" – Rules & Regulations

IN WITNESS WHEREOF, the parties hereto have caused this Lease Agreement to be executed the day and date first above written.

LANDLORD:

1200 POINTE CENTRE PARTNERS, GP

By: _____

Title: Partner

TENANT:

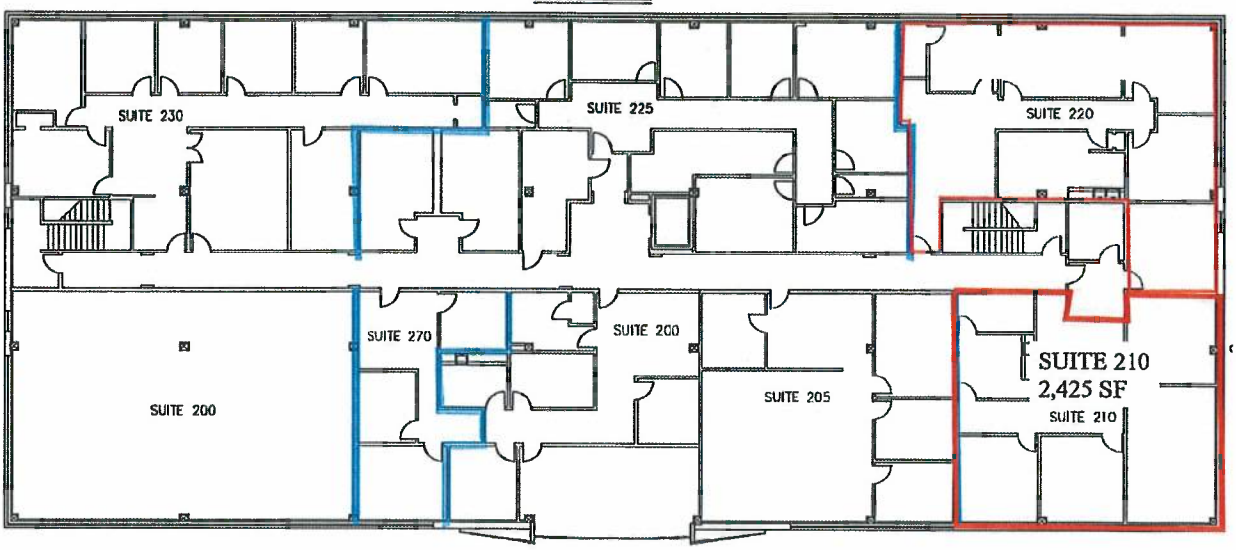
SHALOM HOSPICE OF SOUTHEAST TENNESSEE, LLC

By: _____

Title: CEO

EXHIBIT "A"

Floor Plan



1200 Premier Dr

EXHIBIT "B"

STANDARD WORK LETTER AGREEMENT

Landlord and Tenant are executing simultaneously with this Work Letter Agreement a written Lease of certain premises described in said Lease ("Premises") to which Lease this Work Letter Agreement may be attached.

To induce Tenant to enter into said Lease (which is hereby incorporated by reference to the extent that the provisions of this Agreement may apply thereto) and in consideration of the mutual covenants hereinafter contained, Landlord and Tenant mutually agree as follows:

Landlord shall:

1. Paint walls with flat paint in a color chosen from Landlord's samples,
2. Replace existing cabinetry and clean floor in kitchen.

Landlord, at Landlord's cost, shall provide a build out of the items listed above using building standard materials and finishes. The tenant improvement work ("T.I. Work") shall be paid by the Landlord directly to the general contractor, retained by Landlord, on a progress payment basis as the T.I. Work is completed to the satisfaction of Landlord. All T.I. Work shall become Landlord's property upon installation.

Upon any termination of the lease prior to the expiration date which is sixty-three (63) months from the date of Lease Commencement. Lessee shall in such event pay to Lessor a penalty determined by multiplying the actual cost of the T.I. Work at a cost of funds rate of prime plus one percent as published in the money section of The Wall Street Journal, on the date of Notice or termination (whichever the case may be) but in no event less than nine percent (9%) by a fraction, the numerator of which is the number of months remaining under the Lease, and the denominator of which is sixty (60).

Tenant hereby acknowledges, understands, and agrees that said T.I. Work is provided as an accommodation by Landlord in direct reliance upon Tenant's warranty and covenant that Tenant shall faithfully and timely perform all of Tenant's obligations under this Lease. In the event Tenant fails at any time during the term of this Lease to timely perform any term, condition, or provision of this Lease, including without limitation, the timely payment of Rent, and said default is not cured within ten (10) days after written notice thereof from Landlord, then said T.I. Work cost shall be deemed canceled and withdrawn, and the full unamortized amount thereof shall be immediately due and payable as additional rent without further notice or demand by Landlord to Tenant.

It is agreed that, notwithstanding anything set forth in the Lease to the contrary, Tenant's obligation for the payment of rent thereunder is not dependent upon Landlord's completion of work to be performed by Landlord as hereinabove set forth, provided, however, that if Landlord shall be delayed substantially completing said work as a result of Tenant's request for materials, finishes, additional quantities or installations other than those constituting "Building Standard Work" then Tenant will be invoiced for the changes they made and the cost thereof. Landlord shall repair and/or replace any defects in the T.I. Work within the first twelve (12) months of the lease term.

EXHIBIT "C"

RULES AND REGULATIONS

1 The rights of each Tenant in entrance, corridors, escalators and elevators servicing the Buildingare limited to ingress to and egress from such Tenant's Premises for the Tenant and its employees, licensees and invitees, and no Tenant shall use, or permit the use of, the entrances, corridors, escalators or elevators for any other purpose. No Tenant shall invite to the Tenant's Premises, or permit the visit of, persons in such numbers or under such conditions as to interfere with the use and enjoyment of any of the sidewalks, plazas, entrances, corridors, escalators, elevators and other facilities of the Building and Office Park by any other Tenants. No Tenant shall obstruct, or permit the obstruction of, any of the sidewalks, plazas, entrances, corridors, escalators, elevators, fire exits or stairways of the Building and Office Park. Landlord reserves the right to control and operate the public portions of the Building and Office Park and the public facilities, as well as facilities furnished for the common use of the Tenants, in such manner as it in its reasonable judgment deems best for the benefit of the Tenants generally.

2 Landlord may refuse admission to the Building and Office Park outside of normal Building and Office Park business hours on business days to any person not known to the watchman in charge, or not having a pass issued by Landlord or by the Tenant whose Premises are to be entered, or not otherwise properly identified, and Landlord may require all persons admitted to or leaving the Building and Office Park outside of normal Building and Office Park business hours on business days to provide appropriate identification. Each Tenant shall be responsible for all persons for whom it issues any such pass and shall be liable to Landlord for all acts or omissions of such persons. Any person whose presence in the Building and Office Park at any time shall, in the judgment of Landlord, be prejudicial to the safety, character or reputation of the Building and Office Park or of its Tenants may be denied access to the Building and Office Park or may be ejected therefrom. During any public excitement or commotion, Landlord may prevent all access to the Building and Office Park by closing the doors or otherwise for the safety of the Tenants and protection of property in the Building and Office Park.

3 The cost of repairing any damage to the public portion of the Building and Office Park or to the public facilities to any facilities used in common with other Tenants, caused by a Tenant or its employees, agents, contractors, licensees or invitees, shall be paid by such Tenant.

4 No awnings or other projects shall be attached to the outside walls of the Building and Office Park. No curtains, blinds, shades or screens which are different from the standards adopted by Landlord for the Building and Office Park shall be attached to, or hung in, or used in connection with, any exterior window or door of the Premises of any Tenant, without the prior written consent of Landlord which consent shall not be unreasonably withheld, conditioned or delayed. Such curtains, blinds, shade or screens must be of a quality, type, design and color approved by Landlord, and attached in the manner approved by Landlord.

5 Except as otherwise set forth in the Lease, no lettering, sign advertisement, notice or object shall be displayed in or on the exterior windows or doors of, or on the outside of, any Tenant's Premises, or at any point inside any Tenant's premises where the same might be visible outside of such Premises, without the prior written consent of Landlord which consent shall not be unreasonably withheld, conditioned or delayed. In the event of the violation of the foregoing by any Tenant, Landlord may remove such object or objects without any liability and may charge the expense incurred in such removal to the Tenant violating this rule. Interior signs, elevator designations and lettering on doors and the Building and Office Park directory shall, if and when approved by Landlord, be inscribed, painted or affixed for each Tenant by Landlord at the expense of such Tenant, and shall be of a size, color and style reasonably acceptable to Landlord.

6 The sashes, sash doors, skylights, windows and doors that reflect or admit light and air into the halls, passageways or other public places in the Building and Office Park shall not be covered or obstructed by any Tenant, nor shall any bottles, parcels or other articles be placed on the window sills or on the peripheral air conditioning enclosures, if any.

7 No showcases or other articles shall be put in front of, or affixed to any part of, the exterior of the Building and Office Park, nor placed in the halls, corridors or vestibules of the Building and Office Park.

8 No bicycles, vehicles, animals, fish or birds of any kind shall be brought into or kept in or about the premises of any Tenant or the Building and Office Park.

9 No noise, including but not limited to, music or the playing of musical instruments, recordings, radio or television, which, in the reasonable judgment of Landlord, might disturb other Tenants in the Building and Office Park, shall be made or permitted by any Tenant. Nothing shall be done or permitted in the Premises of any Tenant, which would impair or interfere with the use or enjoyment by any other Tenant of any other space in the Building and Office Park.

10 No Tenant, nor any Tenant's contractors, employees, agents, visitors or licensees, shall at any time bring into or keep upon the premises or the Building and Office Park any inflammable, combustible, explosive or otherwise dangerous fluid, chemical or substance.

11 No additional locks or bolts of any kind shall be placed upon any of the doors or windows in any Tenant's Premises and no lock on any door therein shall be changed or altered in any respect without Landlord's consent, which shall not be unreasonably withheld, conditioned or delayed. Upon the termination of its Tenancy, Tenant shall make a reasonable effort to turn over to Landlord all keys forTenant's premises and toilet rooms, either furnished to, or otherwise procured by, such Tenant.

12 All removals, or the carrying in or out of any safes, freight, furniture, packages, boxes, crates or any other object or matter of any description must take place during such hours and in such elevators and in such manner as Landlord or its agent may reasonably determine from time to time. The persons employed to move safes and other heavy objects shall be reasonably acceptable to Landlord. Arrangements will be made by Landlord with any Tenant for moving large quantities of furniture and equipment into or out of the Building and Office Park. All reasonable labor and engineering costs incurred by Landlord in connection with any moving specified in this rule, including a reasonable charge for overhead and profit, shall be paid by such Tenant to Landlord, on demand.

13 Landlord reserves the right to inspect all objects and matter to be brought into the Building and Office Park and to exclude from the Building and Office Park all objects and matter which violate any of these Rules and Regulations or the Lease of which this Exhibit is a partLandlord shall in no way be liable to any Tenant for damages or loss arising from the admission, exclusion or ejection of any person to or from the Premises or the Building and Office Park under the provisions of this Rule or Rule 2 hereof.

14 Landlord shall have the right to prescribe the weight and position of safes and other objects of excessive weight, and no safe or other object whose weight exceeds the lawful load for the area upon which it would stand shall be brought into or kept in any Tenant's Premises. If, in the judgment of Landlord, it is necessary to distribute the concentrated weight of any heavy object, the work involved in such distribution shall be done at the expense of Tenant and in such manner as Landlord shall determine.

15 Except as otherwise set forth in the Lease, no machinery or mechanical equipment other than ordinary portable business machines may be installed or operated in any Tenant's Premises without Landlord's prior written consent, which consent shall not be unreasonably withheld or delayed, and in no case (even where the same are of a type so excepted or consented to by Landlord) shall any machines or mechanical equipment be so placed or operated as to disturb other Tenants; but machines and mechanical equipment which may be permitted to be installed and used in a Tenant's premises shall be so equipped, installed and maintained by such Tenant as to prevent any disturbing noise, vibration or electrical or other interference from being transmitted from such premises to any other area of the Building and Office Park. Landlord, its contractors, and their respective employees shall have the right to use, without charge therefor, reasonable amount of light, power and water in the Premises of any Tenant while cleaning or making repairs to or alterations in the Premises of such Tenant.

16 The requirements of Tenants will be attended to by Landlord only upon application at the office of the Building and Office Park. Employees of Landlord shall not perform any work or do anything outside of their regular duties, unless under special instructions from Landlord.

17 Canvassing, soliciting and peddling in the Building and Office Park are prohibited, and each Tenant shall cooperate to prevent the same.

18 No Tenant shall cause or permit any unusual or objectionable odors which would annoy other Tenants or create a public or private nuisance to emanate from its Premises. Except for reheating of food in a microwave oven, no cooking shall be done in the Premises of any Tenant except as is expressly permitted in such Tenant's lease.

19 Nothing shall be done or permitted in any Tenant's Premises, and nothing shall be brought into or kept in any Tenant's Premises, which would impair or interfere with any of the Building and Office Park services or the proper and economic heating, cleaning or other servicing of the Building and Office Park or the Tenant's Premises, or the use or enjoyment by any other Tenant of any other Premises, nor shall there be installed by any Tenant any ventilating, airconditioning, electrical or other equipment of any kind which, in the reasonable judgment of Landlord, might cause any such impairment or interference.

20 No acids, vapors or other materials which may damage the waste lines, vents or flues of the Building and Office Park shall be discharged or permitted to be discharged into such waste lines, vents of flues. The water and wash closets and other plumbing fixtures in or serving any Tenant's Premises shall not be used for any purpose other than the purposes for which they were designed or constructed, and no sweeping, rubbish, rags, acids or other foreign substances shall be deposited therein. All damage resulting from misuse of the fixtures shall be borne by the Tenants, who, or whose servants, employees, agents, visitors or licensees shall have caused the same. Any cuspidors or containers or receptacles used as such in the Premises of any Tenant or for garbage or similar refuse, shall be emptied, cared for and cleaned by and at the expense of such Tenant.

21 All entrance doors in each Tenant's Premises shall be left locked and all windows shall be left closed by the Tenant when the Tenant's Premises are not in use. Entrance doors to each Tenant's Premises and to the Building and Office Park shall not be left open at any time. Each Tenant, before closing and leaving its Premises at any time, shall turn out all lights.

22 If Landlord shall elect to install any energysaving film on the windows of the Premises or to install energysaving windows in place of the present windows, each Tenant shall cooperate with the reasonable requirements of Landlord in connection with such installation and permit Landlord or its agents to have access to the Tenant's Premises at reasonable times during business hours to perform such work.

23 No Tenant shall install any resilient tile or similar floor covering in such Tenant's Premises except in such manner as may be reasonably approved by the Landlord.

24 No Tenant, or any employee of any Tenant, shall go upon the roof of the Building and Office Park without the written consent of Landlord.

25 No attachment shall be made to the electriclighting wires of the Building and Office Park for the storing of electricity or for the running of motors or other purposes, nor shall any Tenant use any other method of heating than that provided by Landlord, without the written consent of Landlord. No mechanic shall be allowed to work on the Building and Office Park other than those employed by the Landlord, without the prior written consent of Landlord.

26 Landlord reserves the right to rescind, alter or waiver any rule or regulation at any time prescribed for the Building and Office Park when, in its reasonable judgment, Landlord deems it necessary, desirable or proper for its best interest and for the best interests of the Tenants generally, and all rules and regulations shall be equally applied to all tenants. Landlord shall not be responsible to any Tenant for the

nonobservance or violation of any of the rules and regulations at any time prescribed for the Building and Office Park.

27 Landlord reserves the right to amend or add to these Rules and Regulations at any time, provided that Landlord shall furnish to each Tenant a copy of such amended or additional Rules. Provided, however, that Landlord may not reinstate those Rules and Regulations or portions thereof that have been struck or amended during the negotiation of the Lease. All such deletions and amendments are shown above in blackline format.

9A

Quit Claim Deed Evidencing Landlord Ownership

Instrument: 200912100016B
Book and Page: GI 9073 824
DEED RECORDING FEE $15.00
DATA PROCESSING FEE $2.00
Total Fees: $17.00
User: HCDC\STaylor
Date: 12/10/2009
Time: 11:41:45 AM
Contact: Pam Hurst, Register
Hamilton County, Tennessee

PREPARED BY:
GRANT, KONVALINKA & HARRISON, P.C.
Ninth Floor, Republic Centre
633 Chestnut Street
Chattanooga, Tennessee 37450

RETURN TO:
1200 Pointe Centre Partners, GP
1200 Premier Drive
Suite 210
Chattanooga, TN 37421

QUITCLAIM DEED

KNOW ALL MEN BY THESE PRESENTS that 1200 Pointe Centre Partners, LLC, a Tennessee limited liability company ("Grantor"), for and in consideration of the sum of Ten and No/100 Dollars ($10.00), cash in hand paid, the receipt of which is hereby acknowledged, has bargained, sold and does hereby convey, remise, release and forever quitclaim unto 1200 Pointe Centre Partners, GP, a Tennessee general partnership, ("Grantee"), its successors and/or assigns, its entire right, title and interest in and to a certain tract of land in Hamilton County, Tennessee, described as follows:

IN THE CITY OF CHATTANOOGA, HAMILTON COUNTY, TENNESSEE:
Lot Four (4), CMC Park, as shown by plat of record in Plat Book 70, Page 27, in the Register's Office of Hamilton County, Tennessee.

REFERENCE is made for prior title in deeds recorded in Book 4955, page 144 and Book 6450, page 1, in the Register's Office of Hamilton County, Tennessee.

Grantor and Grantee acknowledge that this Deed was prepared from information furnished by them. No title examination has been made and neither John R. Anderson nor Grant, Konvalinka & Harrison, P. C. shall have any liability for the status of title to the property or for the accuracy of such information.

Address of Grantee	Mail Tax Notice	Map Parcel No.
1200 Pointe Centre Partners, GP 1200 Premier Drive Suite 210 Chattanooga, Tennessee 37421	Same	158G-B-001.01

Book and Page: GI 9073 825

This instrument and the interest hereby released and quitclaimed are subject to such limitations, restrictions and encumbrances as may affect the premises.

IN WITNESS WHEREOF, Grantor has executed and delivered this Quitclaim Deed this 15 day of September, 2009.

1200 Pointe Centre Partners, LLC, a
Tennessee limited liability company

By: _____
Title: Chief Manager

STATE OF TENNESSEE
COUNTY OF HAMILTON

Before me, a Notary Public of the State and County aforesaid, personally appeared, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself to be Chief Manager, of 1200 Pointe Centre Partners, LLC, the within named bargainor, a Tennessee limited liability company, and that he as such officer executed the foregoing instrument for the purposes therein contained by signing the name of the limited liability company by himself as such officer.

WITNESS my hand and seal, this 15 day of September, 2009.

_____
Notary Public

My commission expires:

_____

PENNY M. MANIS
STATE OF TENNESSEE
NOTARY PUBLIC
HAMILTON COUNTY
My Commission Expires June 09, 2013

Book and Page: GI 9073 826

STATE OF TENNESSEE
COUNTY OF HAMILTON

I hereby swear or affirm that, to the best of affiant's knowledge, information and belief, the actual consideration for this transfer is $ -0-.

Affiant-Grantee

Subscribed and sworn to
before me this 15 day
of September, 2009.

Notary Public

My commission expires:

PENNY M. MANIS
STATE OF TENNESSEE
NOTARY PUBLIC
HAMILTON COUNTY
My Commission Expires June 09, 2013

HAMILTON COUNTY
TENNESSEE

Assessor of Property
Marty Haynes

6135 Heritage Park Drive
Bonny Oaks
Chattanooga, TN 37416

Phone: 423-209-7300
Fax: 423-209-7301

Hours: Mon - Fri
8:00am - 4:00pm
Except on Holidays

Card 1 of 1

Location	Property Account Number	Parcel ID
1200 PREMIER DR	146604	158G_B_001.01
Property Type	**Land Use**	**District**
00	630	CITY

Current Property Mailing Address

Owner 1200 POINTE CENTRE PARTNERS GP
Address 1209 POINTE CENTRE DR, STE 101
City CHATTANOOGA
State TN
Zip 37421

Current Property Sales Information

Sale Date 10/2/2011
Sale Price $0
Legal Reference 9504-0770
Grantor(Seller)

Current Property Assessment

Building Value $2,591,800
Xtra Features Value $53,000
Land Value $647,500
Total Value $3,292,300
Assessed Value $1,316,920

Narrative Description

This property is classified as COMMERCIAL with a(n) GENERAL OFFI style structure on this card, built about 2000 with 33,438 square feet.

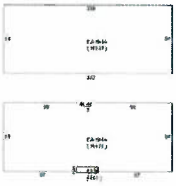
Land Description

The total land area of this property is (2.35 ACRES).

Legal Description
(This Legal Description is for assessment purposes only. For complete Legal, see recorded deed.)

LT 1 CMC PARK PB 63 PG 66 REV 63-86

Property Images



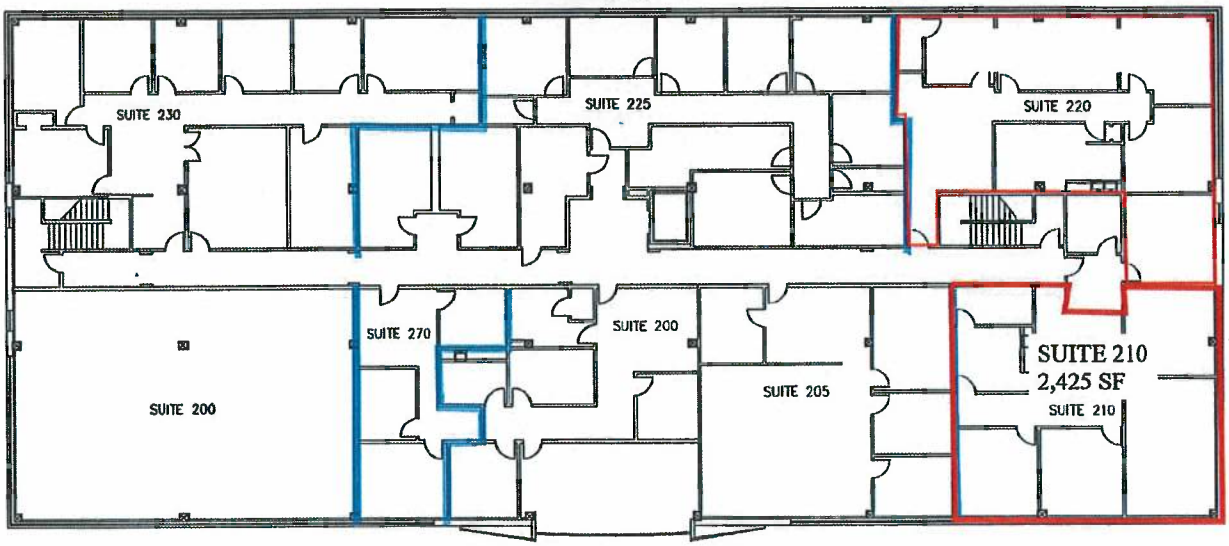
10A

Floor Plan

DocuSign Envelope ID: DFF80341-EE00-4FE2-9B6A-407D05DE3F00

EXHIBIT "A"

Floor Plan

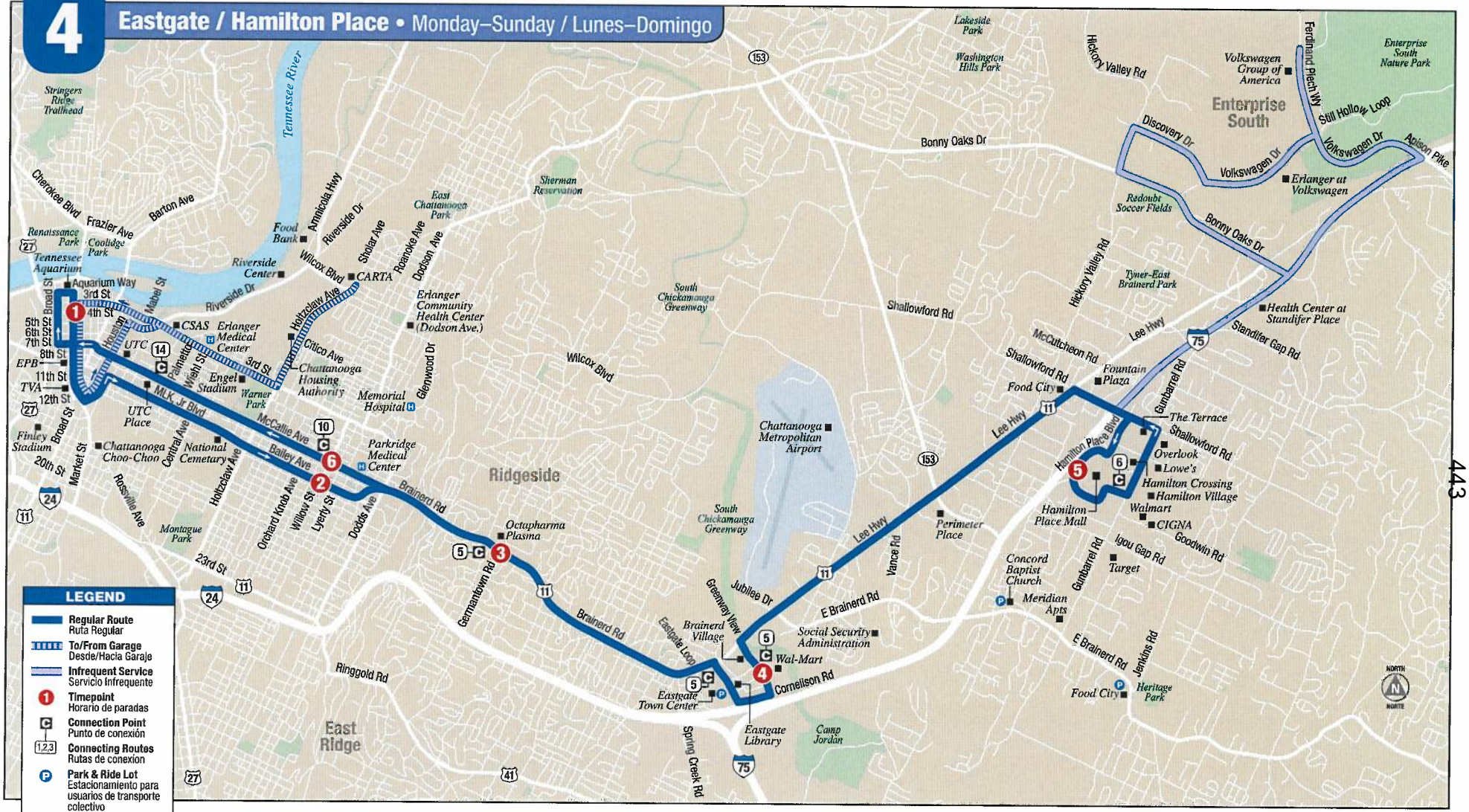


1200 Premier Dr

11A

Public Transportation Routes

4 Eastgate / Hamilton Place • Monday–Sunday / Lunes–Domingo



LEGEND

- **Regular Route** / Ruta Regular
- **To/From Garage** / Desde/Hacia Garaje
- **Infrequent Service** / Servicio Infrequente
- **Timepoint** / Horario de paradas
- **Connection Point** / Punto de conexión
- **Connecting Routes** / Rutas de conexion
- **Park & Ride Lot** / Estacionamiento para usuarios de transporte colectivo
- **Point of Interest** / Punto de interés

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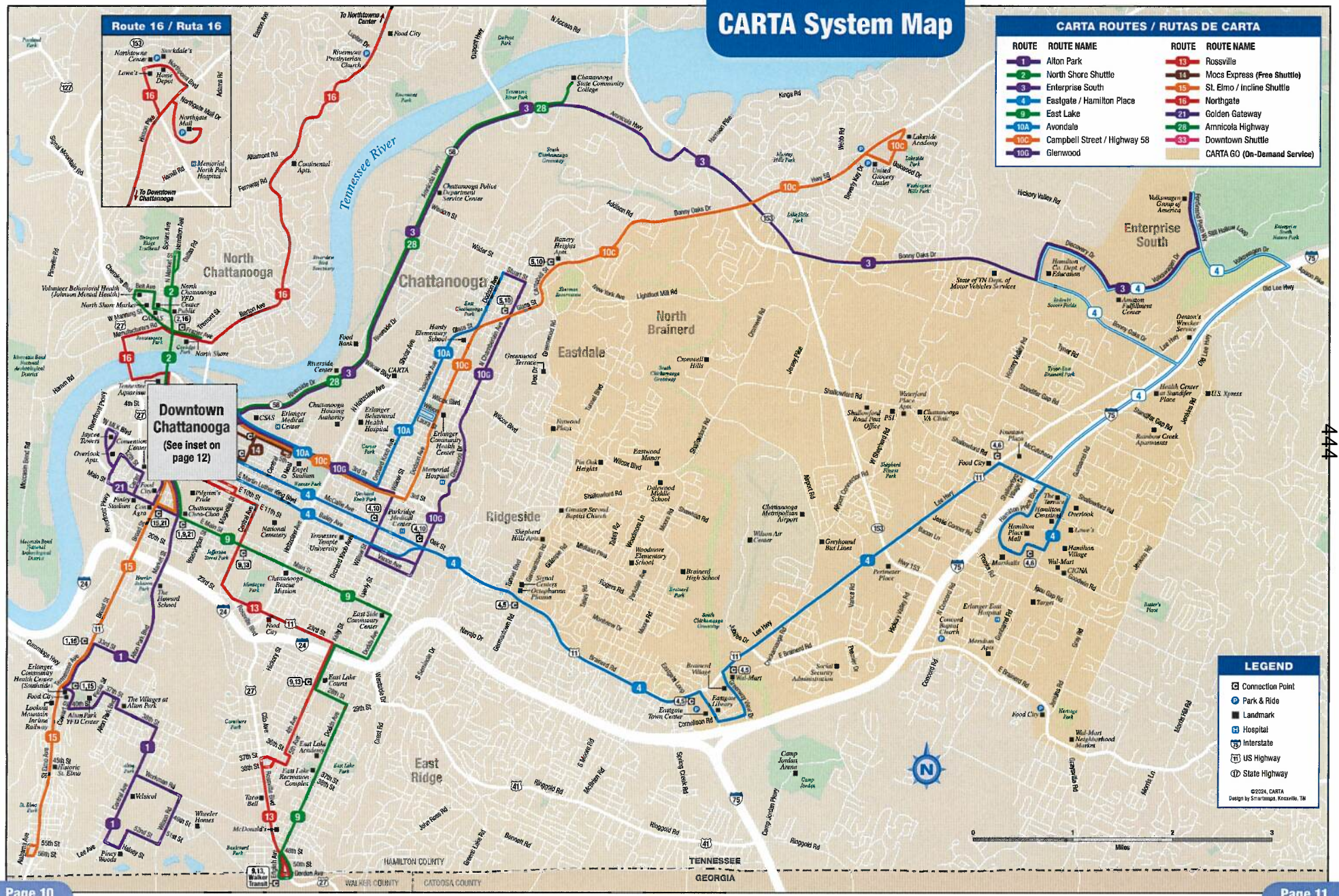
Design by Smartmaps, Inc.

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, Memorial Day and Juneteenth, 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., en el día de Homenaje a los Caídos (Memorial Day) y Juneteenth los buses viajan de acuerdo con el horario del sábado.

***See schedules next page** / Ver horarios página siguiente →*

CARTA System Map



Route 4 Eastgate / Hamilton Place

Please see map on page 26-27
Favor ver el mapa en la página 26-27

← *See Holiday service information on previous page* / *Ver información sobre horario en días festivos en la anterior página*

MONDAY–FRIDAY / LUNES–VIERNES • 4:20 AM – 1:10 AM

	Outbound from Downtown / Saliendo del Centro					Inbound to Downtown / De ida hacia el Centro					
	Bus comes from / Bus viene de	4th & Market 1	Bailey Ave. & Willow St 2	Brainerd & Germantown 3	Wal-Mart (Brainerd) 4	Hamilton Place Mall 5	Hamilton Place Mall 5	Wal-Mart (Brainerd) 4	Brainerd & Germantown 3	McCallie & Willow St 6	4th & Market 1	Bus goes to / Bus va hacia
AM	G-4:40	—	—	—	—	—	5:00	5:30	5:45	5:50	6:10	4
	G-4:20	4:30	4:50	4:55	5:10	5:40	5:40	6:10	6:25	6:30	6:50	4
	G-4:40	4:50	5:10	5:15	5:30	6:00	6:00	6:30	6:45	6:50	7:10	4
	G-5:00	5:10	5:30	5:35	5:50	6:20	6:20	6:50	7:05	7:10	7:30	4
	10A	5:30	5:50	5:55	6:10	6:40	6:40	7:10	7:25	7:30	7:50	G-8:10
	G-5:40	5:50	6:10	6:15	6:30	7:00	7:00	7:30	7:45	7:50	8:10	4
	4	6:10	6:30	6:35	6:50	7:20	7:20	7:50	8:05	8:10	8:30	4
	G-6:20	6:30	6:50	6:55	7:10	7:40	7:40	8:10	8:25	8:30	8:50	4
	4	6:50	7:10	7:15	7:30	8:00	8:00	8:30	8:45	8:50	9:10	4
	4	7:10	7:30	7:35	7:50	8:20	8:20	8:50	9:05	9:10	9:30	4
	4	7:30	7:50	7:55	8:10	8:40	8:40	9:10	9:25	9:30	9:50	G-10:10
	G-7:40	7:50	8:10	8:15	8:30	9:00	9:00	9:30	9:45	9:50	10:10	G-10:30
	4	8:10	8:30	8:35	8:50	9:20	9:20	9:50	10:05	10:10	10:30	G-10:50
	4	8:30	8:50	8:55	9:10	9:40	9:40	10:10	10:25	10:30	10:50	4
	4	8:50	9:10	9:15	9:30	10:00	10:00	10:30	10:45	10:50	11:10	4
	4	9:10	9:30	9:35	9:50	10:20	10:20	10:50	11:05	11:10	11:30	G-11:50
	4	9:30	9:50	9:55	10:10	10:40	10:40	11:10	11:25	11:30	11:50	G-12:10
	G-9:40	9:50	10:10	10:15	10:30	11:00	11:00	11:30	11:45	11:50	**12:10**	4
	G-10:00	10:10	10:30	10:35	10:50	11:20	11:20	11:50	**12:05**	**12:10**	**12:30**	4
	G-10:20	10:30	10:50	10:55	11:10	11:40	11:40	**12:10**	**12:25**	**12:30**	**12:50**	4
	4	10:50	11:10	11:15	11:30	**12:00**	**12:00**	**12:30**	**12:45**	**12:50**	**1:10**	G-1:30
	4	11:10	11:30	11:35	11:50	**12:20**	**12:20**	**12:50**	**1:05**	**1:10**	**1:35**	9
	G-11:20	11:30	11:50	11:55	**12:10**	**12:40**	**12:40**	**1:10**	**1:25**	**1:30**	**1:50**	4
	G-11:40	11:50	**12:10**	**12:15**	**12:30**	**1:00**	**1:00**	**1:30**	**1:45**	**1:50**	**2:10**	1
	4	**12:10**	**12:30**	**12:35**	**12:50**	**1:20**	**1:20**	**1:50**	**2:05**	**2:10**	**2:30**	4
	4	**12:30**	**12:50**	**12:55**	**1:10**	**1:40**	**1:40**	**2:10**	**2:25**	**2:30**	**2:50**	4
	4	**12:50**	**1:10**	**1:15**	**1:30**	**2:00**	**2:00**	**2:30**	**2:45**	**2:50**	**3:10**	4
	G-1:00	**1:10**	**1:30**	**1:35**	**1:50**	**2:20**	**2:20**	**2:50**	**3:05**	**3:10**	**3:30**	4
	G-1:20	**1:30**	**1:50**	**1:55**	**2:10**	**2:40**	**2:40**	**3:10**	**3:25**	**3:30**	**3:50**	10C
	4	**1:50**	**2:10**	**2:15**	**2:30**	**3:00**	**3:00**	**3:30**	**3:45**	**3:50**	**4:10**	4
PM	G-2:00	**2:10**	**2:30**	**2:35**	**2:50**	**3:20**	**3:20**	**3:50**	**4:05**	**4:10**	**4:30**	4
	4	**2:30**	**2:50**	**2:55**	**3:10**	**3:40**	**3:40**	**4:10**	**4:25**	**4:30**	**4:50**	G-5:10
	4	**2:50**	**3:10**	**3:15**	**3:30**	**4:00**	**4:00**	**4:30**	**4:45**	**4:50**	**5:10**	G-5:30
	4	**3:10**	**3:30**	**3:35**	**3:50**	**4:20**	**4:20**	**4:50**	**5:05**	**5:10**	**5:30**	G-5:50
	4	**3:30**	**3:50**	**3:55**	**4:10**	**4:40**	**4:40**	**5:10**	**5:25**	**5:30**	**5:50**	4
	G-3:40	**3:50**	**4:10**	**4:15**	**4:30**	**5:05**	**5:05**	**5:40**	**5:55**	**6:05**	**6:25**	4
	4	**4:10**	**4:30**	**4:35**	**4:50**	**5:20**	**5:20**	**5:50**	**6:05**	**6:10**	**6:30**	G-6:50
	4	**4:30**	**4:50**	**4:55**	**5:10**	**5:40**	**5:40**	**6:10**	**6:25**	**6:30**	**6:50**	4

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

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Route 4 Eastgate / Hamilton Place

Please see map on page 26-27
Favor ver el mapa en la página 26-27

MONDAY–FRIDAY / LUNES–VIERNES • 4:20 AM – 1:10 AM

	Outbound from Downtown / Saliendo del Centro					Inbound to Downtown / De ida hacia el Centro					
	Bus comes from / Bus viene de	4th & Market 1	Bailey Ave. & Willow St 2	Brainerd & Germantown 3	Wal-Mart (Brainerd) 4	Hamilton Place Mall 5	Hamilton Place Mall 5	Wal-Mart (Brainerd) 4	Brainerd & Germantown 3	McCallie & Willow St 6	4th & Market 1	Bus goes to / Bus va hacia
PM	G-4:40	**4:50**	**5:10**	**5:15**	**5:30**	**6:00**	**6:00**	**6:30**	**6:45**	**6:50**	**7:10**	4
	1	**5:10**	**5:30**	**5:35**	**5:50**	**6:20**	**6:20**	**6:50**	**7:05**	**7:10**	***7:30**	4
	G-5:20	**5:30**	**5:50**	**5:55**	**6:10**	**6:45**	**6:45**	**7:15**	**7:30**	**7:35**	**7:55**	4
	4	**5:50**	**6:10**	**6:15**	**6:30**	**7:00**	**7:00**	**7:30**	**7:45**	**7:50**	**8:10**	G-8:30
	3	**6:10**	**6:30**	**6:35**	**6:50**	**7:20**	**7:20**	**7:50**	**8:05**	**8:10**	***8:30**	4
	4	***6:30**	**6:50**	**6:55**	**7:10**	**7:45**	**7:45**	**8:15**	**8:30**	**8:35**	**8:55**	4
	4	**6:50**	**7:10**	**7:15**	**7:30**	**8:00**	**8:00**	**8:30**	**8:45**	**8:50**	**9:10**	G-9:30
	4	**7:10**	**7:30**	**7:35**	**7:50**	**8:20**	**8:20**	**8:50**	**9:05**	**9:10**	***9:30**	4
	4	***7:30**	**7:50**	**7:55**	**8:10**	**8:45**	**8:45**	**9:15**	**9:30**	**9:35**	**9:55**	4
	4	**8:00**ES	**8:20**	**8:25**	**8:40**	**9:10**	**9:10**ES	**9:55**	**10:10**	**10:15**	***10:30**	4
	4	***8:30**	**8:50**	**8:55**	**9:10**	**9:40**	**9:40**	**10:10**	**10:25**	**10:30**	**10:50**	G-11:10
	4	**9:00**	**9:20**	**9:25**	**9:40**	**10:10**	**10:10**R	**10:40**R	**10:55**R	**11:00**R	**11:20**R	G-11:40
	4	***9:30**ES	**9:50**	**9:55**	**10:10**	**10:40**	**10:40**ES	**11:25**	**11:40**	**11:45**	12:00	G-12:20
	4	**10:00**	**10:20**	**10:25**	**10:40**	**11:10**	**11:10**	**11:35**	**11:45**	**11:55**	12:05	G-12:20
	4	***10:30**	**10:50**	**10:55**	**11:10**	**11:40**	**11:40**	12:10	12:25	12:30	12:50	G-1:10

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.

R By passenger request, bus will go to points along the Route 21 Golden Gateway before returning to garage. / A solicitud del pasajero el bus irá a los puntos en la ruta 21 Golden Gateway antes de regreso al garaje.

ES- Indicates when the bus will serve the Enterprise South Industrial Park after leaving from Hamilton Place Mall. Bus will travel to Enterprise South from/to I-75 and will go to points along the Route 3 Enterprise South. Please see map for the routing. / Indica cuándo el bus dará servicio al Enterprise South Industrial Park después de salir de Hamilton Place Mall. El autobús viajará a Enterprise South desde/hacia la I-75 e irá a puntos a lo largo de la Ruta 3 Enterprise South. Consulte el mapa para conocer la ruta.

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

Route 4 Eastgate / Hamilton Place

Please see map on page 26-27
Favor ver el mapa en la página 26-27

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SATURDAY / SÁBADO • 4:50 AM – 12:40 AM

	Outbound from Downtown / Saliendo del Centro					Inbound to Downtown / De ida hacia el Centro					
	Bus comes from / Bus viene de	1 4th & Market	2 Bailey Ave. & Willow St	3 Brainerd & Germantown	4 Wal-Mart (Brainerd)	5 Hamilton Place Mall	5 Hamilton Place Mall	4 Wal-Mart (Brainerd)	3 Brainerd & Germantown	6 McCallie & Willow St	1 4th & Market	Bus goes to / Bus va hacia
AM	G-4:50	5:00	5:15	5:20	5:30	6:00	6:00	6:25	6:35	6:40	7:00	4
	10A	5:30	5:45	5:50	6:00	6:30	6:30	6:55	7:05	7:10	7:25	G-7:45
	G-5:50	6:00	6:15	6:20	6:30	7:00	7:00	7:25	7:35	7:40	8:00	4
	G-6:20	6:30	6:45	6:50	7:00	7:30	7:30	7:55	8:05	8:10	8:30	4
	4	7:00	7:15	7:20	7:30	8:00	8:00	8:25	8:35	8:40	9:00	4
	G-7:20	7:30	7:45	7:50	8:00	8:30	8:30	8:55	9:05	9:10	9:30	4
	4	8:00	8:15	8:20	8:30	9:00	9:00	9:25	9:35	9:40	10:00	4
	4	8:30	8:45	8:50	9:00	9:30	9:30	9:55	10:05	10:10	10:25	G-10:45
	4	9:00	9:15	9:20	9:30	10:00	10:00	10:30	10:40	10:45	11:00	G-11:20
	4	9:30	9:45	9:50	10:00	10:30	10:30	10:55	11:05	11:10	11:30	4
	4	10:00	10:15	10:20	10:30	11:00	11:00	11:25	11:35	11:40	**12:00**	4
	G-10:20	10:30	10:45	10:50	11:00	11:30	11:30	11:55	**12:05**	**12:10**	**12:30**	4
	G-10:50	11:00	11:15	11:20	11:30	**12:00**	**12:00**	**12:25**	**12:35**	**12:40**	**1:00**	4
	4	11:30	11:45	11:50	**12:00**	**12:30**	**12:30**	**1:00**	**1:10**	**1:15**	**1:30**	4
PM	4	**12:00**	**12:15**	**12:20**	**12:30**	**1:00**	**1:00**	**1:30**	**1:40**	**1:45**	**2:00**	G-2:20
	4	**12:30**	**12:45**	**12:50**	**1:00**	**1:30**	**1:30**	**2:00**	**2:10**	**2:15**	**2:30**	G-2:50
	4	**1:00**	**1:15**	**1:20**	**1:30**	**2:00**	**2:00**	**2:30**	**2:40**	**2:45**	**3:00**	G-3:20
	4	**1:30**	**1:45**	**1:50**	**2:00**	**2:30**	**2:30**	**3:00**	**3:10**	**3:15**	**3:30**	G-3:50
	G-1:50	**2:00**	**2:15**	**2:20**	**2:30**	**3:00**	**3:00**	**3:30**	**3:40**	**3:45**	**4:00**	G-4:20
	G-2:20	**2:30**	**2:45**	**2:50**	**3:00**	**3:30**	**3:30**	**3:55**	**4:05**	**4:10**	**4:25**	G-4:45
	G-2:50	**3:00**	**3:15**	**3:20**	**3:30**	**4:00**	**4:00**	**4:30**	**4:40**	**4:45**	**5:00**	4
	G-3:20	**3:30**	**3:45**	**3:50**	**4:00**	**4:30**	**4:30**	**5:00**	**5:10**	**5:15**	**5:30**	4
	G-3:50	**4:00**	**4:15**	**4:20**	**4:30**	**5:00**	**5:00**	**5:30**	**5:40**	**5:45**	**6:00**	4
	G-4:20	**4:30**	**4:45**	**4:50**	**5:00**	**5:30**	**5:30**	**5:55**	**6:05**	**6:10**	***6:30**	4
	4	**5:00**	**5:15**	**5:20**	**5:30**	**6:00**	**6:00**	**6:25**	**6:35**	**6:40**	**7:00**	4
	4	**5:30**	**5:45**	**5:50**	**6:00**	**6:30**	**6:30**	**6:55**	**7:05**	**7:10**	***7:30**	4
	4	**6:00**	**6:15**	**6:20**	**6:30**	**7:00**	**7:00**	**7:25**	**7:35**	**7:40**	**8:00**	4
	4	***6:30**	**6:50**	**6:55**	**7:05**	**7:30**	**7:30**	**7:55**	**8:05**	**8:10**	***8:30**	4
	4	**7:00**	**7:20**	**7:25**	**7:35**	**8:00**	**8:00**	**8:25**	**8:35**	**8:40**	**9:00**	4
	4	***7:30**	**7:50**	**7:55**	**8:05**	**8:30**	**8:30**R	**8:55**R	**9:05**R	**9:10**R	***9:30**R	4
	4	**8:00**ES	**8:15**	**8:20**	**8:30**	**9:00**	**9:00**ES	**9:35**	**9:45**	**9:50**	**10:05**	4
	4	***8:30**	**8:50**	**8:55**	**9:05**	**9:30**	**9:30**	**9:55**	**10:05**	**10:10**	***10:30**	4
	4	**9:00**	**9:20**	**9:25**	**9:35**	**10:00**	**10:00**R	**10:25**R	**10:35**R	**10:40**R	**10:55**R	G-11:10
	4	***9:30**ES	**9:50**	**9:55**	**10:05**	**10:30**	**10:30**ES	**11:05**	**11:15**	**11:20**	**11:35**	G-11:55
	4	**10:05**	**10:25**	**10:30**	**10:40**	**11:05**	**11:05**	**11:30**	**11:40**	**11:45**	12:00	G-12:15
	4	***10:30**	**10:50**	**10:55**	**11:05**	**11:30**	**11:30**	**11:55**	12:05	12:10	12:25	G-12:40

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

Route 4 Eastgate / Hamilton Place

Please see map on page 26-27
Favor ver el mapa en la página 26-27

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

SUNDAY / DOMINGO • 9:10 AM – 8:10 PM

	Outbound from Downtown / Saliendo del Centro						Inbound to Downtown / De ida hacia el Centro					
	Bus comes from / Bus viene de	1 4th & Market	2 Bailey Ave. & Willow St	3 Brainerd & Germantown	4 Wal-Mart (Brainerd)	5 Hamilton Place Mall	5 Hamilton Place Mall	4 Wal-Mart (Brainerd)	3 Brainerd & Germantown	6 McCallie & Willow St	1 4th & Market	Bus goes to / Bus va hacia
AM	G-9:10	9:20	9:35	9:40	9:55	10:25	10:25	10:55	11:05	11:10	11:30	**21**
	21	*10:10	10:35	10:40	10:55	11:20	11:20	11:50	**12:00**	**12:05**	**12:25**	G-12:45
	G-11:10	*11:20	11:45	11:50	**12:05**	**12:30**	**12:30**	**1:00**	**1:10**	**1:15**	***1:40**	**21**
	21	**12:10**	**12:25**	**12:30**	**12:45**	**1:15**	**1:15**	**1:45**	**1:55**	**2:00**	**2:20**	**21**
PM	**1**	**12:40**	**12:55**	**1:00**	**1:15**	**1:45**	**1:45**	**2:15**	**2:25**	**2:30**	***2:50**	**21**
	21	**1:20**	**1:35**	**1:40**	**1:55**	**2:25**	**2:25**	**2:55**	**3:05**	**3:10**	**3:30**	**21**
	21	**2:30**	**2:45**	**2:50**	**3:05**	**3:35**	**3:35**	**4:05**	**4:15**	**4:20**	**4:40**	G-5:00
	21	**3:00**	**3:15**	**3:20**	**3:35**	**4:05**	**4:05**	**4:35**	**4:45**	**4:50**	**5:10**	G-5:30
	21	***4:00**	**4:25**	**4:30**	**4:45**	**5:15**	**5:15**	**5:45**	**5:55**	**6:00**	***6:30**	**21**
	21	**5:00**	**5:15**	**5:20**	**5:35**	**6:05**	**6:05**	**6:35**	**6:45**	**6:50**	**7:10**	**21**
	21	**5:50**	**6:05**	**6:10**	**6:25**	**6:50**	**6:50**	**7:20**	**7:30**	**7:35**	**7:50**	G-8:10

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.

R By passenger request, bus will go to points along the Route 21 Golden Gateway before line-up trip or returning to garage. / A solicitud del pasajero el bus irá a los puntos en la ruta 21 Golden Gateway antes del viaje para formar línea o de regreso al garaje.

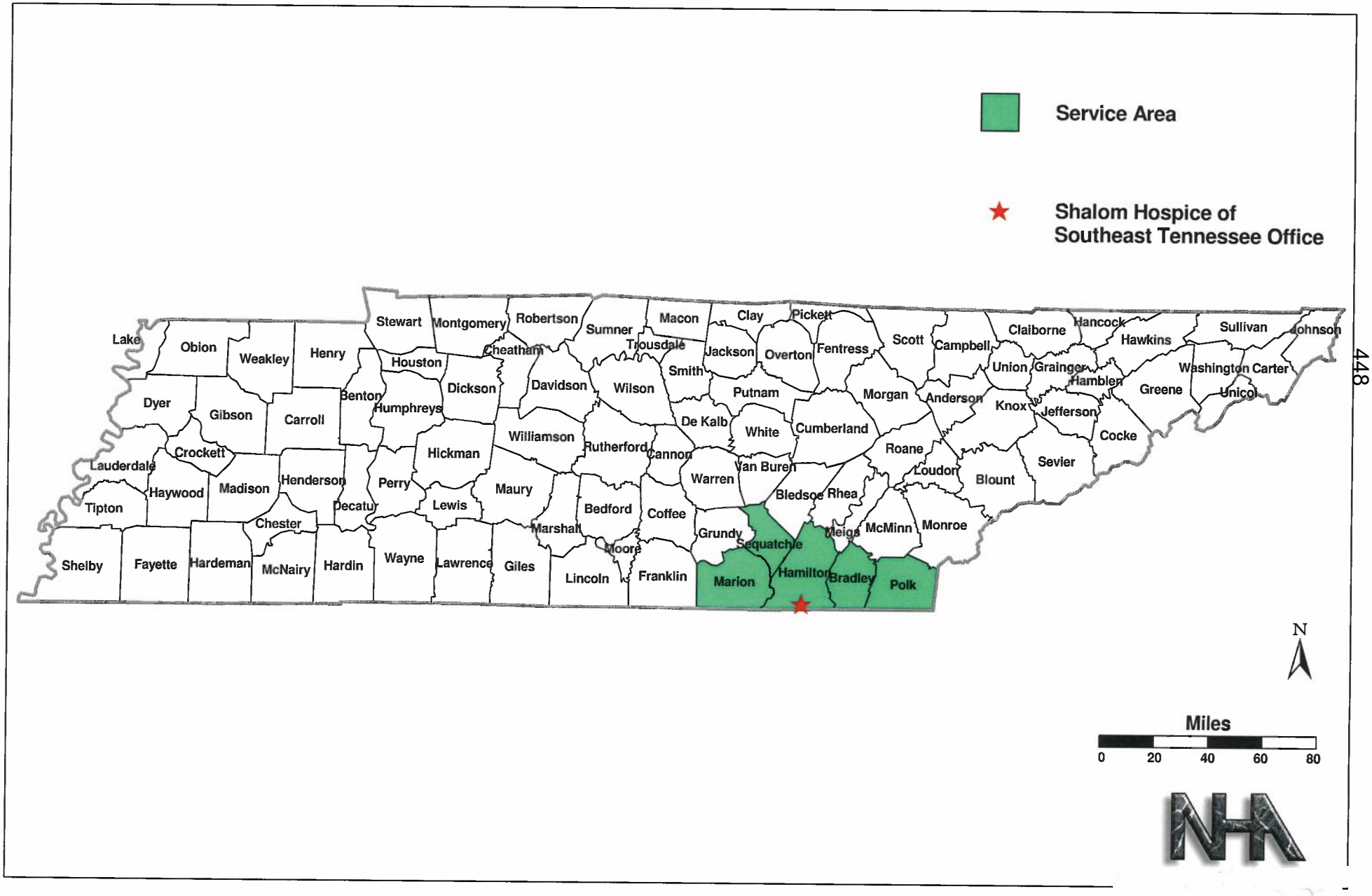
ES- Indicates when the bus will serve the Enterprise South Industrial Park after leaving from Hamilton Place Mall. Bus will travel to Enterprise South from/to I-75 and will go to points along the Route 3 Enterprise South. Please see map for the routing. / Indica cuándo el bus dará servicio al Enterprise South Industrial Park después de salir de Hamilton Place Mall. El autobús viajará a Enterprise South desde/hacia la I-75 e irá a puntos a lo largo de la Ruta 3 Enterprise South. Consulte el mapa para conocer la ruta.

2N

Service Area Map

Shalom Hospice of Southeast Tennessee

Project Service Area



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)

Complete the following utilization tables for each county in the service area, if applicable.

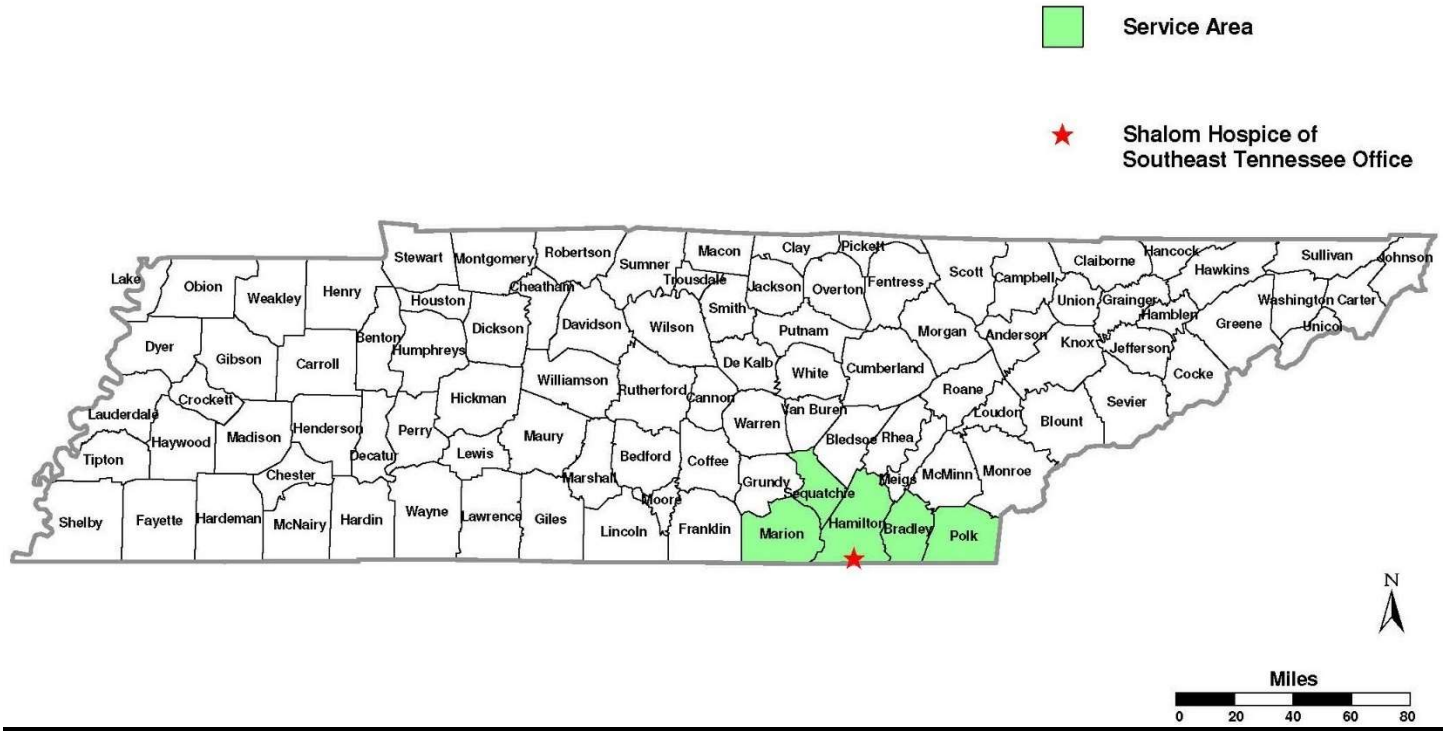
RESPONSE:

Shalom Hospice's defined service area is a five-county contiguous service area which has Hamilton County as its center. The five counties are Hamilton, Bradley, Marion, Polk and Sequatchie. It is these five counties that are home to the vast majority of Jewish persons residing in Southeast Tennessee. Its centralized office location in Chattanooga (Hamilton County) is proximate to the geographic center of this Service Area. Further, Hamilton and Bradley Counties, the two most populated counties in the Service Area, are central to the Service Area with only one county to the east and two counties to the west.

A map of the service area's geographic position relative to the entire state is illustrated below. The county map is included as **Attachment 2N**.

Shalom Hospice of Southeast Tennessee

Project Service Area

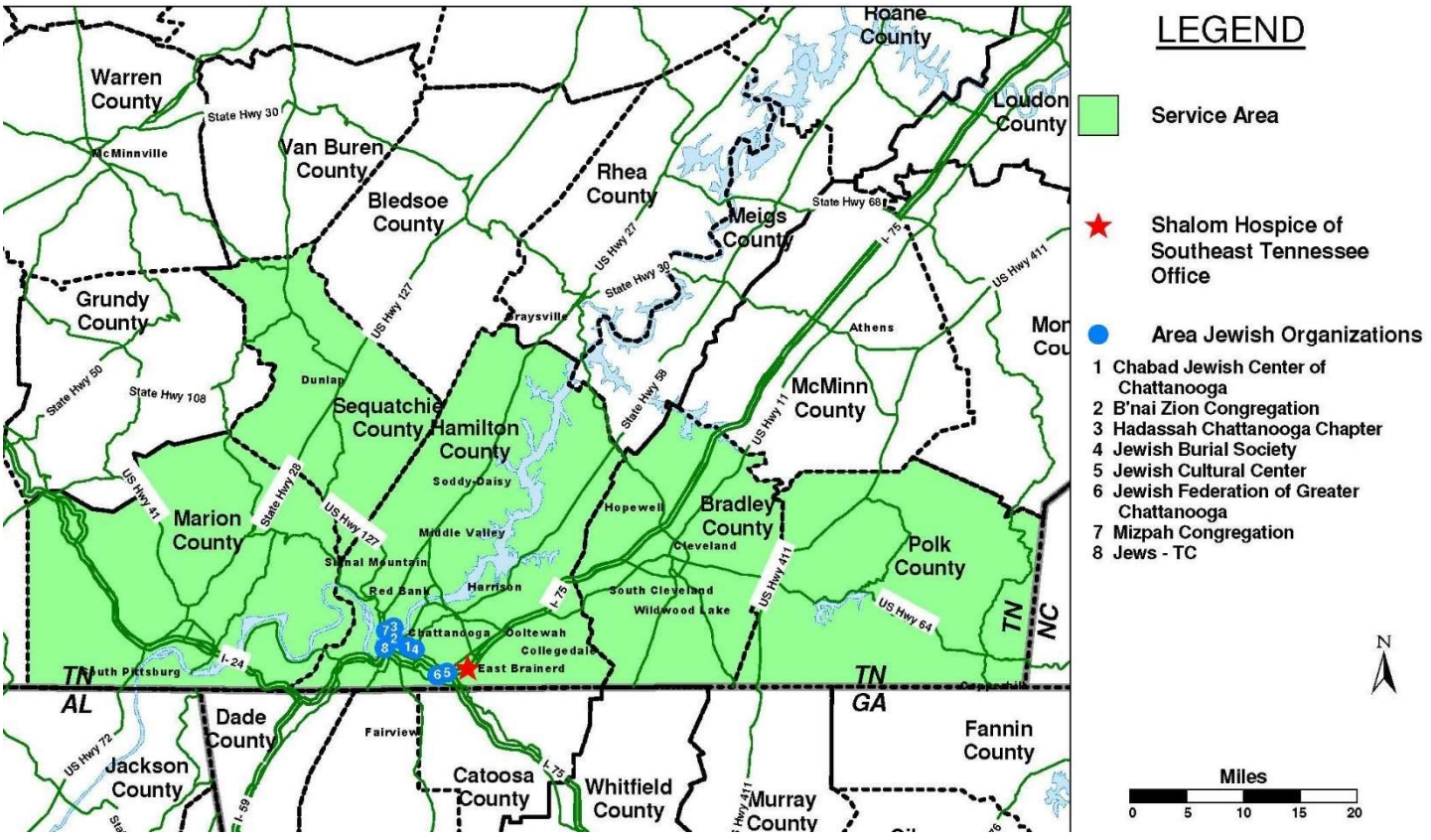


The next map provides an illustration of the five-county service area with Shalom Hospice's centralized office location identified by a red star and the area Jewish congregations and other institutions plotted. Synagogues have historically been the primary religious institution for Jews in the United States and the traditional means for formal affiliation with the Jewish community. For some, synagogue membership is primarily an expression of religious belief, and overall, synagogue members have higher rates of participation in religious and Jewish ritual life than do non-members. For others, synagogue membership is primarily related to communal affiliation. The other identified institutions are also resources for Jewish communal activities, affairs and events.

In addition to synagogues identified on this map, also included are other Jewish organizations that serve as cornerstones of affiliated Jewish persons to engage in religious and secular activities. These include the Jewish Federation and Jewish Cultural Center, University of Tennessee Chattanooga student group, community centers, school, leadership program among others. These organizations operate as influencers within the community, also expressing support for establishment of Shalom Hospice and the need for a Jewish hospice. The visual in the map below identifies the Shalom Hospice's location relative to the Jewish resources throughout the region.[1]

Shalom Hospice of Southeast Tennessee

Area Jewish Organizations



In addition to the Jewish resources identified above, there are a number of assisted living facilities and nursing homes throughout the Service Area with Jewish residents/patients. In total, there are 43 nursing homes and assisted living facilities in the Service Area; at this early stage, 13 or 30 percent have provided letters of support to Shalom Hospice to meet the needs of their patients. This includes 20 percent of the facilities in Bradley

[1] Although the Service Area counties are contiguous to adjacent states, the Applicant does not plan on serving patients in these other states bur rather just serving patients within the defined service area.

County, 34 percent of the facilities in Hamilton County and 50 percent of the facilities in Marion County. Upon CON licensure, Shalom Hospice will continue meeting with these facilities and others to establish contractual relationships to provide Jewish end of life care for their patients. These letters are included in **Attachment 1N-2** and discussed within the CON application.

Additionally, Shalom Hospice has identified more than five assisted living facilities throughout the five county area which indicate they provide assisted living services for Jewish persons. It is Shalom Hospice's intent to meet with each of these identified assisted living facilities after CON approval to develop a community linkage plan with those organizations. The list of assisted living facilities who identify as having Jewish programming is included in **Attachment 1N-2.** It should be noted that Shalom Hospice has initiated meetings with some of these facilities, two of which have provided letters of support included herein.

The Jewish community's institutions are heavily concentrated in near downtown and the Brainerd area of Hamilton County as portrayed in the above map. This area has excellent access to Interstate 75 and Interstate 24 among other state routes and highways. The nursing homes and assisted living facilities are dispersed throughout the five-county region as indicated by Shalom Hospice's research, community linkages and support. Offering Jewish hospice programming in the five-county Service Area will expand the reach of the Jewish community and provide unavailable services to the Jewish population.

As discussed throughout this CON application, the Applicant is well qualified to license and implement an in-home hospice service to successfully penetrate the Jewish community that resides within the Service Area. Shalom Hospice has no historical utilization in the Service area.

The Applicant projects it will admit 79 patients during its first year of operation, approximately 1.4 percent of the Service Area total admissions. Consistent with the Jewish population's county of residence 16 admissions to Shalom Hospice will be patients of Bradley County, 49 from Hamilton County, 6 from Marion County and 4 each from Polk and Sequatchie Counties as presented in the following table.

Service Area Counties	**Projected Utilization County Residents – Year 1 (Year=1/1/2025-12/31/2025)**	**% of Total** X **Cases**
Bradley County	16	20%
Hamilton County	49	62%
Marion County	6	8%
Polk County	4	5%
Sequatchie County	4	5%
Total	79	100%

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).

RESPONSE:

The service area is home to 557,675 total residents and by 2028, this count is expected to increase by 2.5 percent, to 571,821 people. Of the approximate 558,000 currently residing in the area, 111,211 are 65 years of age and older. This cohort will exceed the overall population growth in the ensuing four years; it is projected to increase 7.8 percent, to nearly 120,000 seniors. It is this older age cohort who are the most frequent utilizers of end of life care and are the target population identified in the table below.

Of the five counties in the Service Area, Hamilton at its center is most populous with more than 383,000 residents representing 69 percent of the Service Area. Of the 383,000 residents, 75,000 are 65 and older and, by 2028 Hamilton County is projected to be home to nearly 81,000 seniors. Hamilton County seniors represent 67 percent of all seniors projected to reside in the five-county Service Area in 2028. As expected, the rural counties surrounding both Hamilton and Bradley have a disproportionate elderly population which is consistent with the older population and older median age within those counties.

The second most populous county is Bradley County at nearly 113,000, expected to increase to 116,171 in 2028, a 3 percent change. Its senior population is 21,740 expected to increase to 23,790 in 2028, a 9.4 percent change. The remaining three counties have between 15,754 and 28,886 population count. Their elderly population ranges between 3,756 and 6,518, or 22.5 to 23.8 percent of total. By 2028, the percent elderly will range between 23.9 and 25.3 percent of total. Median age exceeds 43 in these three rural counties while Bradley and Hamilton median ages are 39.6 and 39.4, respectively.

Overall, the Service Area senior population is 19.9 percent of total population in 2024. By 2028, this will increase to 21.0 percent. Of the total population growth of 14,000 during the next four years, more than 8,600 – or 62 percent – will be seniors. The percent elderly in the Service Area exceeds the corresponding percent in the state of Tennessee.

The median age in the Service Area is approximately 40 years of age. Hamilton County has the youngest median age of 39.4 and Bradley has 39.6. All other Service Area counties have median age ranging between 43.4 and 46.1. The median household income in the Service Area counties ranges between $53,000 and $69,000, with the highest being Hamilton County which has the majority of the population and households.

The three rural Service Area counties (Marion, Polk and Sequatchie) exceed the State and Service Area average for percentage of persons below poverty level. Approximately 12.4 percent of the total Service Area population live below the poverty level which is lower than the State's 13.3 percent.

In aggregate, as of April 2024, there were 108,864 TennCare enrollees in the Service Area representing 19.5 percent of total population. The three rural counties, plus Bradley County, also exceed the Service Area and State TennCare enrollee percentage.

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 2024	Total Population-Projected Year 2028	Total Population-% Change 2024-2028	*Target Population-Ages 65+ Current Year 2024	Target Population-Ages 65+ Projected Year 2028	Target Population-% Change, 2024-2028	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
Bradley County	112,767	116,171	3.0%	21,740	23,790	9.4%	20.5%	39.6	$60,692	14,772	13.1%	24,329	21.6%
Hamilton County	383,109	393,234	2.6%	75,214	80,749	7.4%	20.5%	39.4	$69,069	45,207	11.8%	69,605	18.2%
Marion County	28,886	28,750	-0.5%	6,518	6,865	5.3%	23.9%	43.4	$58,139	4,015	13.9%	6,942	24.0%
Polk County	17,159	17,410	1.5%	3,983	4,338	8.9%	24.9%	46.1	$53,775	2,642	15.4%	3,993	23.3%
Sequatchie County	15,754	16,256	3.2%	3,756	4,111	9.5%	25.3%	44.6	$53,038	2,757	17.5%	3,995	25.4%
SERVICE AREA	**557,675**	**571,821**	**2.5%**	**111,211**	**119,853**	**7.8%**	**21.0%**	**40.0**	**--**	**69,394**	**12.4%**	**108,864**	**19.5%**
State of TN	7,125,908	7,331,859	2.9%	1,324,362	1,438,845	8.6%	19.6%	39.2	$64,035	947,746	13.3%	1,511,132	21.2%

Source: Tennessee Department of Health, Census.gov Quick Facts May 2024 and ACS survey for median age by county and state, and Division TennCare, Enrollment as of April 2024 (latest available). TennCare Enrollees as % of Total is TennCare Enrollees (April 2024) divided by Total Population 2024.

Target Population is the 65 and older population.

Jewish Demographics

A subset of the aforementioned population is the Jewish people of the Service Area. Southeast Tennessee is home to a stable community of Jews. Pew Research Center estimates the Jewish population to represent 2.4 percent of the total U.S. population. This differs state to state and community to community. The estimate of the Jewish population in the Service Area is between 3,000 and 4,000 persons. Compared with the overall public, the Jewish population is older, derived from the Pew Research Center's 2021 study of the American Jewish population.[2] This is consistent with the observations about the Jewish population in the Service Area. Older adults are more in need of healthcare services and are generally the primary users of healthcare including in-home hospice services.

Chattanooga was founded in 1839. Although there is some record of Jewish settlement in Chattanooga prior to the Civil War, the beginnings of the first Jewish community appeared in Chattanooga in the years after. From these initial settlers, a vital community grew and continues to today.

Throughout the past several decades, the Jewish South has been transformed, as generations of Jewish merchants have given way to Jewish professionals and executives. In Chattanooga, like Knoxville, Jews began to arrive in significant numbers after the Civil War. Chattanooga became a major railroad hub between the South, Midwest and Eastern Seaboard and later grew into a regional manufacturing center in the early 20th century. The city's economic prosperity attracted increasing numbers of Jews. By 1937, 3,800 Jews were living in Chattanooga.

The history of Jewish life in the area around Chattanooga and Cleveland unfolded according to the general pattern of Jewish settlement in the Southern interior. Most of the early congregations in Tennessee were founded by Jewish immigrants from Germany who eventually embraced Reform Judaism. The Eastern European immigrants established their own Orthodox congregations. Chattanooga followed this same pattern. The Bach family arrived from Germany in the 1860s and began holding services in their home in 1866; these were largely for Jewish soldiers who remained in Chattanooga at the conclusion of the war. In May of that year, a group organized the Hebrew Benevolent Association which purchased land and established a Jewish cemetery. This group received a boost with the arrival of Rabbi Fischer in 1869; it began to hold worship services and eventually grew into Knoxville's first Jewish congregation. The Rabbi also established a religious school. Subsequent leadership also organized the Hebrew Ladies Aid Society (1877).

Many of the leaders of the Hebrew Benevolent Association went into retail business and participated in the reconstruction.

Other prominent families included the Ochs family. Adolph Ochs at the age of 19 purchased the controlling share of the Chattanooga Times. After building that newspaper into a success, he went on to purchase the New York Times in 1886 and within three years had successfully expanded that business. Mr. Ochs was a significant benefactor in Chattanooga, helping to build the public library, roads, hospitals, public parks and opera house.

The Hebrew Benevolent Association officially affiliated with the Union of American Hebrew Congregations in 1883. This reform congregation's first temple was built in the 1880's on Walnut Street and named Mizpah Congregation. In 1904 it built a new synagogue on Lindsay and Oak Streets.

Beginning in the 1880s, increasing numbers of Jewish arrivals from Eastern Europe began to settle in the area. This included the Brody family which held the first Orthodox services in their home. In 1888, they adopted the name B'nai Zion and began renting publics spaces for their expanded services. In 1902, this congregation built its first synagogue at 14th and Carter Streets.

[2] https://www.pewresearch.org/religion/2021/05/11/jewish-demographics/

With the growth of both congregations, Mizpah Congregation built a new temple on McCallie in 1928 which is its current location. By 1931, B'nai Zion built its new temple on Vine Street. Today, these same streets are where one finds the current Mizpah Congregation, B'nai Zion Congregation and Chabad of Chattanooga.

The Siskin family, which arrived in 1895, started a hugely successful steel and scrap metal business. Connected to healthcare, years later after a near fatal train accident in 1942, Garrison Siskin pledged to devote substantial resources to helping others. He and his brother established the Siskin Memorial Foundation in 1950. In 1990, this Foundation provided funding for Chattanooga's Siskin Hospital for Physical Rehabilitation.

By the early 20th century, the Jewish community of Chattanooga supported a wide array of social clubs and activities. Early organizations included branches of B'nai Brith, Hadassah, Workman's Circle, YMHA (Young Men's Hebrew Association), Young Judea Club, Jewish Boy Scouts of America as well as men's and women's and children's clubs affiliated with the congregations. By the early 1920s, Mizpah operated a Sunday School and B'nai Zion organized a Religious School in 1934.

Chattanoogan Harry Miller organized the Chattanooga Jewish Welfare Agency in 1931, supporting Jewish and public causes in Chattanooga and around the country. In 1938, this agency obtained a formal charter as the Chattanooga Jewish Federation. The Chattanooga Jewish Community Center was organized in 1944 and operated independently until merging with the Federation in 1993.

In the early 1960s, members of B'nai Zion changed the congregation's affiliation from Orthodox to Conservative. The congregation also purchased property on McBrien Road in Brainerd. By 1975, it relocated to this new synagogue. Subsequently, another group formed an Orthodox congregation. Today, Chabad of Chattanooga continues the Orthodox tradition in this area.

Chattanooga at its peak had 3,800 Jewish residents. Today, the southeast area – including Chattanooga, Cleveland and surrounding communities are estimated to have a Jewish population exceeding 3,000 persons. Insight from local rabbis and Jewish organizational leadership estimates the range throughout this region is between 3,000 and 4,000 Jewish persons. Extrapolating the Jewish persons to households which would include non-Jewish individuals results in a total of between 4,000 and 4,500 people living in Jewish households. These Jewish residents and their families continue to support a broad range of religious and communal functions.

As noted previously, synagogues are the traditional means for affiliation within the Jewish community. Most of the service area institutions are clustered near downtown and the Brainerd area in Hamilton County. Service Area population from Hamilton and the surrounding counties access these institutions on a regular basis. A brief description of the synagogues as well as the other organizations identified in the above map are as follows:

- Chabad Jewish Center of Chattanooga is located at 950 Vine St, Chattanooga, TN 37403 in the historic Fort Wood area of Chattanooga. Chabad of Chattanooga has been in the community since 2009. It features a synagogue, library and other spaces for learning and special events. In addition to serving the 3,000+ Jews in the area, Chabad has established a close rapport with many of the Jewish college and medical students from University of Tennessee – Chattanooga and Erlanger Hospital and participates in the Jews – TC (discussed below). In addition, it has a Hebrew School, summer camp, Kosher kitchen and educational services. Rabbi Shaul Perlstein leads this Orthodox congregation which has a following of nearly 800 families.

- B'nai Zion Congregation is temporarily located at 923 McCallie Avenue, Chattanooga, TN 37403. It was most recently in the Brainerd area on McBrien Road but temporarily relocated to McCallie Avenue until its new synagogue is complete. Its history is detailed above, starting as an Orthodox congregation in the late 1800s and changing to Conservative in the 1960s. Its Sisterhood was formed in 1903, its Hebrew School in 1909 and its Sunday School in 1934. Today, it has at least 300 families who are affiliated. Rabbi Sam Rotenberg leads this congregation.

- Mizpah Congregation is also located at 923 McCallie Avenue, Chattanooga, TN 37403. This is the Reform congregation that is the oldest congregation in Chattanooga, established 150+ years ago in 1866 with its Sisterhood being established in 1877. Its building was designated as a Tennessee Historical Preservation Site in 1979, completed a sanctuary artistic project with glass windows in its sanctuary in 1997, in 1999 added a 'garden of life' for communal gathering and in 2012 completed a massive restoration and refurbishment project. In addition to religious services, it provides adult education as well as education for youth and children. Today, it has a membership of 250 families.

- Jewish Federation of Greater Chattanooga is located at 5461 North Terrace Road, Chattanooga, TN 37411. It is the central voluntary communal organization in the region and builds and fosters a strong unified Jewish community, striving to ensure its well-being and continuity locally, in Israel and throughout the world. Its history, starting as the Jewish Welfare Agency in 1931 is also detailed above. This organization communicates with 1,300 families in the region.

- Jewish Cultural Center is located at 5461 North Terrace Road, Chattanooga, TN 37411. This center, funded by the Federation, is a venue for programs, classes, exhibits, socials services and a pre-school, all rooted in Jewish values. It enables the Jewish community to raise its visibility, foster relationships and strengthen its identity in the region.

- Hadassah Chattanooga Chapter is located at 923 McCallie Ave, Chattanooga, TN 37403. Its local members include women from the area who are also affiliated with Chabad, Mizpah Congregation, B'nai Zion Congregation, and the Jewish Cultural Center among other organizations. It is a volunteer organization whose purpose is to support hospitals in Israel, younger Jewish groups, and is involved in health awareness and humanitarian relief. It enhances the health of people worldwide through its support of medical care and research.

- Jewish Burial Society, 950 Vine St, Chattanooga, TN 37403. The Jewish Burial Society, known as Chevra Kadisha, is an organization of Jewish men and women who see to it that the bodies of deceased Jews are prepared for burial according to Jewish tradition and are protected from desecration, willful or not, until burial. Two of the main requirements are the showing of proper respect for a corpse, and the ritual cleansing of the body and subsequent dressing for burial. This organization is active in southeast Tennessee and is based out of the Jewish Center.

- Jews – TC, 615 McCallie Avenue, Chattanooga, TN 37403, is located at the University of Tennessee – Chattanooga campus. It is the only such program in the area for Jewish students. The Chabad Jewish Center provides space for this group to meet off campus, enabling both a religious and cultural environment.

The congregations in the area have a list of an estimated 1,350 which may include duplicates but is generally consistent with the Jewish Federation mailing list of 1,300 families. Notably, research conducted in other communities suggest that less than half of Jewish households belong to at least one synagogue.[3] Extrapolating the families who 'belong' to total current households, and eliminating for potential double counts, can be accomplished by factoring for those who do not belong to a synagogue. This would indicate there are likely 1,800+ Jewish households in the Service Area. Applying an estimated average household size to the number of households results in a total estimate between 4,000 and 4,500 household members of Jewish families in the area. This confirms the reported number of Jewish persons and Jewish households previously identified.

As indicated in the American Jewish Population Project, nationally 21.5 percent of the adult population is 65 years of age and older. However, within the Jewish segment of the adult population, 31.8 percent are 65 years

[3] The 2015 Nashville and Middle Tennessee Jewish Community Study, Matthew Boxer, Janet Krasner Aronson, Matthew A. Brookner, Ashley Perry, Brandeis University, May 2016. In Middle Tennessee, only four out of ten households belonged to a synagogue. That data was extrapolated to account for the other six households. Here, a conservative estimate of one half was utilized to confirm the demographic characteristics of the Service Area.

of age and older.[4] The median age of Jewish adults is 57, somewhat older than the national median age of 50. As the population continues to age, there will be greater need for hospice services, and specifically Jewish hospice services uniquely tailored to the unique needs of this cohort.

In a prior study of the Nashville area, it was found that two-thirds (66%) of adults would be more inclined to use social services offered by a Jewish organization. Highly affiliated Jewish adults expressed stronger preference (78%) for Jewish providers of social services than do unaffiliated adults (40%).[5] Discussions with Greater Chattanooga Jewish leadership acknowledged these rates and confirmed similar sentiments for Southeast Tennessee. This observation also confirms the inherent support for Shalom Hospice as expressed by leaders of Jewish congregations, healthcare providers with Jewish patients and organizations who provided letters of support for this CON application.

Given quantification of Jewish population and households, the older age of that population and the meaningful support by Jewish leaders in addition to healthcare referrals sources, forecasting 79 admissions in the first year of this proposed hospice service is a reasonable estimate of utilization for Shalom Hospice.

[4] AJPP Technical Report 2020: Zip Code Based Jewish Population Estimates, Cohen Center for Modern Jewish Studies, Steinhardt Social Research Institute, page 21.
[5] The 2015 Nashville and Middle Tennessee Jewish Community Study, Matthew Boxer, Janet Krasner Aronson, Matthew A. Brookner, Ashley Perry, Brandeis University, May 2016. This information is used as a reference point.

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:

The previously presented chart in response to Item 3N indicates 12.4 percent of the Service Area population lives below poverty level and there are 108,864 TennCare enrollees (19.5 percent of the Service Area population) living in the five-county area. Consistent with the overall population, and its experience, Shalom Hospice expects that a portion of Jewish households are receiving public benefits and that a portion are economically vulnerable and would benefit from additional assistance. The Applicant will provide hospice services to all patients who are clinically appropriate for end of life care, regardless of their ability to pay. It has incorporated into its revenues an allowance for three percent charity care and an estimated patient population of eight percent TennCare.

There is currently no Jewish Hospice agency in the Greater Chattanooga or surrounding area. As indicated by the many letters of support for this project, the Jewish community has not been well served by the existing hospice agencies in that they are not equipped to address the specific special needs of the Jewish people that provides personalized care within the framework of Jewish law and ritual.

Shalom Hospice will provide Jewish hospice care to Jewish patients in a manner that recognizes Jewish heritage, history and traditions. Shalom Hospice is different than existing hospice agencies in the Service Area that make it uniquely positioned and qualified to serve the Jewish people throughout this five-county Service Area. Shalom Hospice is Jewish owned and operated thus by its very nature, it is in tune with the cultural sensitivities and religious beliefs required to serve this special population.

Specifically, Affinity Care and its affiliates are led by Mr. Samuel Stern. Mr. Stern is an Orthodox Jew and schooled in the associated teachings. Mr. Stern – the face of the Shalom Hospice program -- has a degree in Talmudic Law[6]. He is intimately familiar with the needs, rituals, practices and traditions and will work alongside the Shalom Hospice team to effectively meet the needs of its patients.

Shalom Hospice's plan to serve the special population in the Service Area will establish specific protocols for meeting the special needs of the Jewish population. It will have a focus on the providing recognition and support for holocaust survivors, addressing pain control measures, providing life sustaining measures in accordance with religious observances, coordinating with and having available support from local Rabbis for spiritual care, guidance and consultation, and coordinating with Chabad, Jewish Cultural Center, Jewish Federation and its partners to ensure patient plans of care include recognition of Kosher diet requirements of patients. Shalom Hospice has established six operational programs and strategies to effectively operate its Jewish hospice program. These are not available in the service area and distinguish Shalom Hospice from any other area provider.

First, Shalom Hospice will address the Jewish end of life needs of Jewish patients by becoming the very first hospice agency in Southeast Tennessee to become accredited through the National Institute for Jewish Hospice. This accreditation provides staff training on the cultural beliefs and sensitivities so that the hospice provider can better serve the Jewish terminally ill. Only 1 percent of hospice programs in the United States are NIJH accredited. Shalom Hospice in Middle Tennessee was CHAP certified in early February 2023 and received its NIJH accreditation later that month, in February 2023. Shalom Hospice of Greater Knoxville was certified in April 2024 and received its NIJH accreditation prior to that, in January 2024. Copies of both accreditation certificates are included as **Attachment 4N**.

[6] The Talmud is the central text of Rabbinic Judaism and the primary source of Jewish religious law (halakha) and Jewish theology. Until the advent of modernity, in nearly all Jewish communities, the Talmud was the centerpiece of Jewish cultural life and was foundational to "all Jewish thought and aspirations", serving also as "the guide for the daily life" of Jews.

Additionally, Mr. Stern and the rest of Affinity Care's officers (Financial, Compliance, Palliative, etc) have received training and accreditation by NIJH. Their accreditation certificate is also located in **Attachment 4N.** Furthermore, Affinity Care's triage team, on-call nurses and compliance team have all received NIJH training and accreditation as part of the home office to enable each of them to be responsive to any patient throughout the Affinity Care network, including Shalom Hospice of Southeast Tennessee once operational.

The National Institute for Jewish Hospice began in 1985 by Rabbi Maurice Lamm. He was the first Orthodox rabbi on the board of the Jewish Federation in Los Angeles. He traveled to hospices around the country to train hospice team members to care for the dying Jewish population in their communities. Today, NIJH hosts conferences whereby staff members attend comprehensive training. Through the NIJH training, staff members gain enhanced understanding of Jewish culture and religion, and their impact on death and dying. This enables them to then integrate understanding of Jewish medical ethics into hospice care, and understand Jewish grief and mourning. Sample topics covered in training include staff members are trained to understand all aspects of Jewish Heritage & Holidays, Jewish Medical Ethics and The Final Journey — Death, Burial and Mourning. Further, they are given vidui cards, Jewish living wills, explanation of the tahara process and an explanation of the custom to use a plain wooden coffin. Accredited agencies are given many materials like the book Prayer and Hope written Rabbi Lamm with Rabbi Bulka.

Another dimension of this first strategy for the Shalom Hospice program is to ascribe to Chayim Aruchim. Chayim Aruchim – The Center for Culturally Sensitive Health Advocacy and Counseling, a project of Agudath Israel of America, was created in 2010 to help the Jewish community make end of life health care decisions according to their religious beliefs. The client profile of Chayim Aruchim is a seriously ill patient where cure may no longer be probable, but appropriate treatments can keep the person comfortable and alive for a significant amount of time. The mission of Chayim Aruchim is dedicated to helping members of the Jewish community make end-of-life health care decisions in keeping with their religious beliefs and according to halacha. With a team of halachic authorities, legal experts, medical, patient and pastoral care professionals and high-level government policy advocates, Chayim Aruchim endeavors to serve as a vital resource in championing, promoting and ensuring the implementation of preferences of Torah observant patients' care decisions in compliance with halacha. Shalom Hospice will incorporate the Halacha Medical Directive[7], a copy of which is supplied in **Attachment 1N-17**.

The Applicant will also look to *Jewish Ritual, Reality and Response at the End of Life: A Guide for Caring for Jewish Patients and Their Family* as an additional valuable resource for patient care at the end of life, as well as its usefulness as an interesting exploration of Judaism's rich traditions. A copy of this guide prepared by Rabbi Mark A. Popovsky for the Duke Institute on Care at the End of Life is supplied in **Attachment 1N-17**.

Second, Shalom Hospice will employ a rabbi to serve as a chaplain on the hospice team. Shalom Hospice plans to employ an Orthodox Rabbi to lead the spiritual counseling of this hospice. Orthodox Rabbis are most familiar with the traditions, rituals and culture. It has been learned that even though a Jewish person may not be religious or practice throughout his/her life, as they near the end of life these religious aspects become ever so important. Having an Orthodox Rabbi to lead the program and provide education, counseling, spiritual support and then bereavement counseling will be of particular importance to patients and their families. Regarding the Affinity Care affiliates, Orthodox Rabbis are employed in each of the States to provide spiritual support as one of the hospice chaplains. Of note, while Shalom Hospice will place an emphasis on serving the Jewish people, it will not deny non-Jewish patients. If its non-Jewish patients wish to be visited by a chaplain of any other faith or denomination, Shalom Hospice will effectuate that request.

Third, Shalom Hospice will work with the Jewish Cultural Center, Jewish Federation and local Rabbis to sponsor quarterly community education events and workshops at the Chabad Jewish Center, Jewish Cultural Center or other community centers and congregations regarding the benefits of hospice services, including an explanation of the hospice benefit available under Medicare, the interdisciplinary team approach to care for patients in

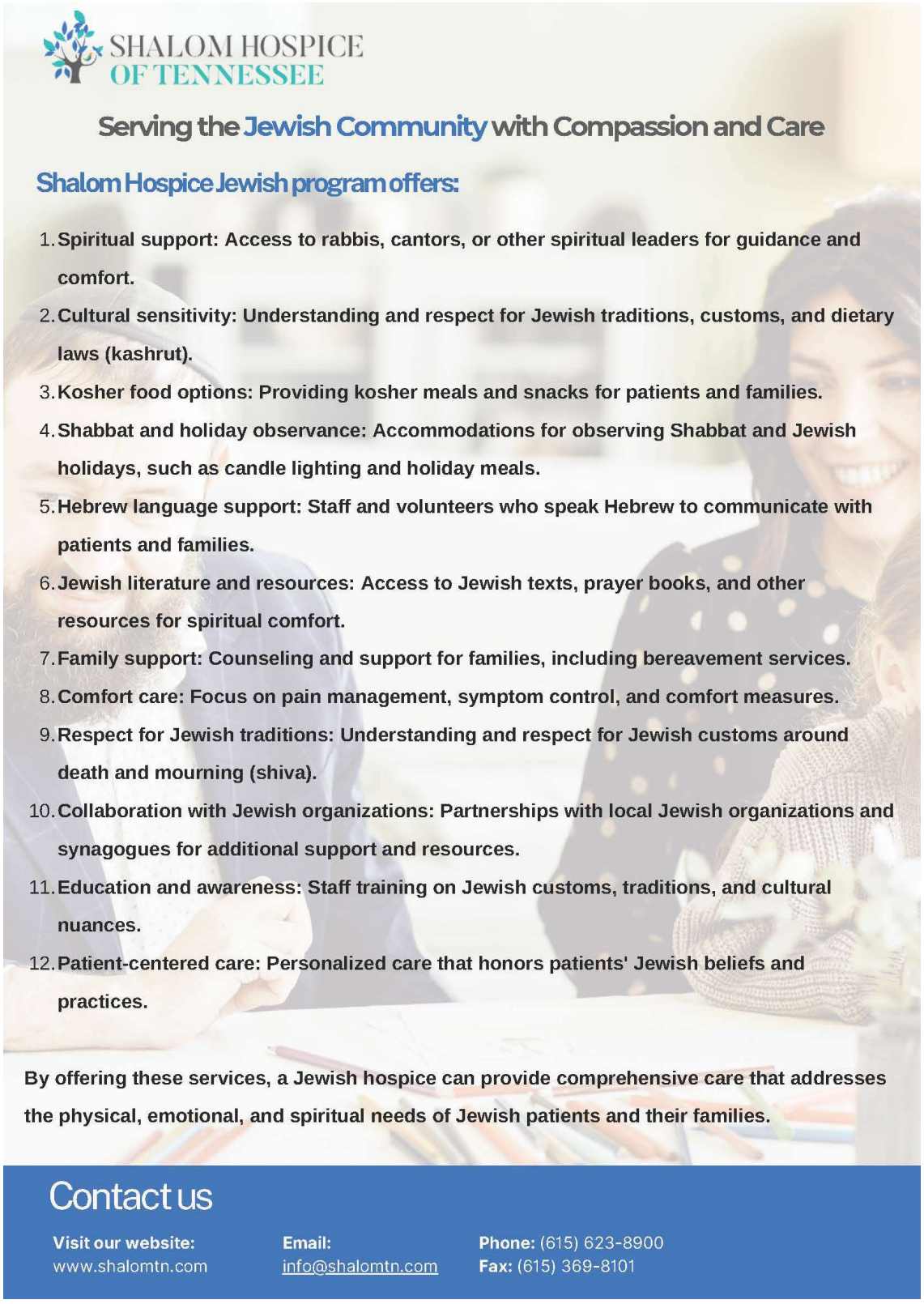
[7] The "Halachic Medical Directive" is designed to help ensure that all medical and post-death decisions made by others on the patient's behalf will be made in accordance with Jewish law and custom (halacha).

hospice, and the ways in which hospice can meet the physical, emotional, and spiritual needs of the Jewish patient and the patient's family at the end of life. Affinity Care affiliates have extensive experience in identifying underserved population groups and designing outreach and education to access and lift up the underserved groups resulting in increasing hospice penetration and enhancing access amongst the population. Affinity Care has designed such programs in other communities to meet the needs of underserved.

With respect to specific Jewish population, Shalom Hospice in Middle Tennessee has designed a specific program to work with Jewish Federation of Nashville and Middle Tennessee (JFNMT) and local rabbis and is already seeing the success of that endeavor. It is also engaging in the educational programs it designed for its constituents, with these programs being co-sponsored with Chabad of Nashville, JFNMT and four of the area nursing homes. These nursing homes include Bethany Center for Rehab & Healing, Center for Rehab and Healing, Nashville Center for Rehab and Healing and Trevecca Center for Rehab and Healing.

Similarly, Shalom Hospice of Greater Knoxville has initiated its community marketing efforts and collaboration with the existing Jewish organizations in the community in its short 2 ½ months since certification. It is engaging in various educational events with Chabad of Knoxville, Knoxville Jewish Alliance and several area nursing homes and assisted living facilities. These facilities include Creekview Health & Rehab (Knox County), Beverly Park Place (Knox County), Island Home (Knox County), West Hills (Knox County), Jefferson City Health & Rehab (Jefferson County), Norris Post-Acute & Rehabilitation Center (Anderson County), Smoky Mountain Post-Acute & Rehabilitation Center (Sevier County) and The Waters of Clinton (Anderson County). Approximately 20 percent of its admissions are Jewish patients with the Jewish population estimated at less than one percent.

Following is a promotional flyer for Shalom Hospice and the program and benefit it offers:



See **Attachment 1N, Criterion #1** for further discussion about Shalom Hospice operations in Middle Tennessee and the Greater Knoxville area.

Fourth, Shalom Hospice's plan is to have a Jewish services coordinator on its staff available to respond to needs of Jewish patients, and to be available to respond to any requests from Jewish Cultural Center, Chabad Jewish Center, Jewish Federation and any other Jewish community organization for assistance and evaluation of patients, including but not limited to 24/7 triage coverage, physical visits to assess hospice eligibility of patients and admission regardless of ability to pay (charity patients); and availability of palliative care programs for Jewish patients that are in need of support but do not presently meet the requirements for admission to hospice care. Given the nature of Shalom Hospice, and the plan to license and certify a hospice with a special emphasis on the Jewish population, the Jewish Services Coordinator will be the lead person coordinating amongst the constituents and Shalom Hospice. This Coordinator will work closely with Mr. Stern as an Orthodox person, CEO of the entity and educated in Talmud Law; work closely with the Orthodox Rabbi as the spiritual leader; and work with the identified community organizations and the community at large.

Fifth, Shalom Hospice will develop a bereavement program specifically designed to address the needs of the Jewish patients, families, caregivers and those who are in need of grief support regardless of whether they are associated with hospice services. Shalom Hospice will utilize the services of an Orthodox Rabbi to lead this program and provide these services to its patients and their families.[8] In Affinity Care's other programs, Rabbis who are part of the chaplaincy program provide bereavement for the Jewish patients under their care. In contrast, existing providers often utilize interfaith chaplains to provide these services.

Sixth, the Applicant worked with Rendever, its Virtual Reality designer, to create a special virtual reality platform for the Jewish population that honors the history and plight of the Jewish experience and provides "travel" to religiously significant sites and experiences throughout the world. All patients at Shalom Hospice will be assessed during the intake process and throughout their care by the care team for the benefits of the Virtual Reality Program. VR goggles are provided by Rendever as well as the tablets for the staff to guide experiences. As it relates to the Jewish hospice patient, Rendever and Shalom Hospice developed a Jewish hospice virtual reality experience. Shalom Hospice and Rendever previously signed an MOU for Rendever to make this platform available to Davidson, Williamson and Rutherford County Jewish residents who wish to utilize the platform. The program has been developed and is now deployed in Middle Tennessee and the Greater Knoxville area. More details on what the Jewish virtual reality experience entails was provided in response to **Question 1N-2.**

All Affinity Care programs utilize the innovative virtual reality programming for the benefit of its patients and their families; an estimated 95 percent participate. With respect to Shalom Hospice in Middle Tennessee, all of its patient admitted since becoming operational last year who are clinically capable have utilized the virtual reality technology. Similarly, since becoming operational in the Greater Knoxville area, approximately half of the patients in that program to date have utilized the virtual reality program. Program descriptions, related policy and procedure and video links are provided in the CON application. See **Question 1N, #6** and **Attachment 1N-6**.

[8] Interfaith chaplains will be available for non-Jewish patients.

The most recent promotional information on Shalom Hospice being shared with the community is the following:

Given Shalom Hospice's plan to serve the Jewish population as delineated above in addition to ensuring it will provide hospice services to all patients who are clinically appropriate for end of life care, regardless of their ability to pay, the Applicant satisfies this criterion.

4N

Shalom Hospice NIJH Accreditation

National Institute for Jewish Hospice

Awards

ACCREDITATION

To

Shalom Hospice

Brentwood, Tennessee

In recognition of satisfactorily completing the requirements
as put forth by the National Institute for Jewish Hospice

Presented this day, the 3rd day of January, 2024
for the period of
January 3, 2024 through December 31, 2024

Shirley Lamm
President, NIJH

1985 - 2024

38 YEARS

National Institute for Jewish Hospice

Awards

ACCREDITATION

To

Shalom Hospice of Greater Knoxville

Knoxville, Tennessee

In recognition of satisfactorily completing the requirements
as put forth by the National Institute for Jewish Hospice

Presented this day, the 3rd day of January, 2024
for the period of
January 3, 2024 through December 31, 2024

Shirley Lamm
President, NIJH

1985 - 2024

38 YEARS

National Institute for Jewish Hospice

Awards

ACCREDITATION

To

Affinity Health Management

Brooklyn, New York

In recognition of satisfactorily completing the requirements
as put forth by the National Institute for Jewish Hospice

Presented this day, the 3rd day of January, 2024
for the period of
January 3, 2024 through December 31, 2024

Shirley Lamm
President, NIJH

1985 - 2024

38 YEARS

5N

Licensed Hospices in the Service Area, TDOH

Hospice Agencies Licensed to Serve Listed Counties *As of 5/14/2024*

Health Statistics ID	Agency County	Agency	Type	Licensed County	County Contains Home Office	County Contains Branch Office
06063 & 06613	Bradley	Adoration Home Health & Hospice Care East TN	Both	Bradley	Yes	No
06603	Bradley	Kindred Hospice	Hospice	Bradley	Yes	No
19694	Davidson	Avalon Hospice	Hospice	Bradley	No	No
33603	Hamilton	Amedisys Hospice an Adventa Company	Hospice	Bradley	No	No
33653	Hamilton	Caris Healthcare	Hospice	Bradley	No	No
33643	Hamilton	Gentiva	Hospice	Bradley	No	No
33673	Hamilton	Hearth Hospice of Tennessee	Hospice	Bradley	No	Yes
33613	Hamilton	Hospice of Chattanooga Inc	Hospice	Bradley	No	Yes
47602	Knox	Amedisys Hospice an Adventa Company	Hospice	Bradley	No	No
		Number of Licensed Agencies Serving Bradley County		**9**		
06063 & 06613	Bradley	Adoration Home Health & Hospice Care East TN	Both	Hamilton	No	Yes
06603	Bradley	Kindred Hospice	Hospice	Hamilton	No	No
19694	Davidson	Avalon Hospice	Hospice	Hamilton	No	Yes
33603	Hamilton	Amedisys Hospice an Adventa Company	Hospice	Hamilton	Yes	No
33653	Hamilton	Caris Healthcare	Hospice	Hamilton	Yes	No
33643	Hamilton	Gentiva	Hospice	Hamilton	Yes	No
33673	Hamilton	Hearth Hospice of Tennessee	Hospice	Hamilton	No	No
33613	Hamilton	Hospice of Chattanooga Inc	Hospice	Hamilton	Yes	Yes
47602	Knox	Amedisys Hospice an Adventa Company	Hospice	Hamilton	No	No
		Number of Licensed Agencies Serving Hamilton County		**9**		
06063 & 06613	Bradley	Adoration Home Health & Hospice Care East TN	Both	Marion	No	No
19694	Davidson	Avalon Hospice	Hospice	Marion	No	No
33603	Hamilton	Amedisys Hospice an Adventa Company	Hospice	Marion	No	Yes
33653	Hamilton	Caris Healthcare	Hospice	Marion	No	No
33643	Hamilton	Gentiva	Hospice	Marion	No	No
33673	Hamilton	Hearth Hospice of Tennessee	Hospice	Marion	No	No
33613	Hamilton	Hospice of Chattanooga Inc	Hospice	Marion	No	Yes
		Number of Licensed Agencies Serving Marion County		**7**		

Hospice Agencies Licensed to Serve Listed Counties *As of 5/14/2024*

Health Statistics ID	Agency County	Agency	Type	Licensed County	County Contains Home Office	County Contains Branch Office
06063 & 06613	Bradley	Adoration Home Health & Hospice Care East TN	Both	Polk	No	No
06603	Bradley	Kindred Hospice	Hospice	Polk	No	No
19694	Davidson	Avalon Hospice	Hospice	Polk	No	No
33603	Hamilton	Amedisys Hospice an Adventa Company	Hospice	Polk	No	No
33653	Hamilton	Caris Healthcare	Hospice	Polk	No	No
33643	Hamilton	Gentiva	Hospice	Polk	No	No
33673	Hamilton	Hearth Hospice of Tennessee	Hospice	Polk	No	No
33613	Hamilton	Hospice of Chattanooga Inc	Hospice	Polk	No	No
47602	Knox	Amedisys Hospice an Adventa Company	Hospice	Polk	No	No
		Number of Licensed Agencies Serving Polk County		**9**		
06063 & 06613	Bradley	Adoration Home Health & Hospice Care East TN	Both	Sequatchie	No	No
19694	Davidson	Avalon Hospice	Hospice	Sequatchie	No	No
33603	Hamilton	Amedisys Hospice an Adventa Company	Hospice	Sequatchie	No	No
33653	Hamilton	Caris Healthcare	Hospice	Sequatchie	No	No
33643	Hamilton	Gentiva	Hospice	Sequatchie	No	No
33673	Hamilton	Hearth Hospice of Tennessee	Hospice	Sequatchie	No	No
33613	Hamilton	Hospice of Chattanooga Inc	Hospice	Sequatchie	No	No
47602	Knox	Amedisys Hospice an Adventa Company	Hospice	Sequatchie	No	No
		Number of Licensed Agencies Serving Sequatchie County		**8**		

Hospice Agencies Licensed to Serve Hamilton and Surrounding Counties *As of 5/14/2024*

Health Statistics ID	Agency County	Agency	Type
06063 & 06613	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
33653	Hamilton	Caris Healthcare	Hospice
33643	Hamilton	Gentiva	Hospice
33673	Hamilton	Hearth Hospice of Tennessee	Hospice
33613	Hamilton	Hospice of Chattanooga Inc	Hospice
47602	Knox	Amedisys Hospice an Adventa Company	Hospice

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 9 licensed in-home hospice agencies serving one or more Service Area county. By county, the number of licensed agencies is as follows:

- Bradley County: 9 agencies
- Hamilton County: 9 agencies
- Marion County: 7 agencies
- Polk County: 9 agencies
- Sequatchie County: 8 agencies

Based on agencies serving multiple counties, in aggregate, there are 9 licensed hospices collectively serving the Service Area. The list of licensed agencies is supplied on the following chart identifying which Service Area counties each serves.

Licensed Hospice Agencies by Service Area County
Calendar Year 2023

State ID	Hospice Agency	Bradley	Hamilton	Marion	Polk	Sequatchie	Total
06063/06613	Adoration Home Health and Hospice Care East TN	X	X	X	X	X	
06603	Kindred Hospice	X	X		X		
19694	Avalon Hospice	X	X	X	X	X	
33603	Amedisys Hospice an Adventa Co	X	X	X	X	X	
33643	Gentiva	X	X	X	X	X	
33653	Caris Healthcare	X	X	X	X	X	
33673	Hearth Hospice of Tennessee	X	X	X	X	X	
33613	Hospice of Chattanooga Inc	X	X	X	X	X	
47602	Amedisys Hospice an Adventa Co	X	X		X	X	
	TOTAL LICENSED	**9**	**9**	**7**	**9**	**8**	**9**

Source: TN Department of Health Licensure - 5/14/2024

In total, there were 5,451 patients served in 2023. Of the 5,451 total in-home hospice admissions, there were 3,920 admissions in Hamilton County, which represents 72 of the Service Area admissions. The next greatest County was Bradley with 920 admissions. The other three counties admitted between 156 and 287 patients, each representing approximately five percent or less of total Service Area patients. All in-home hospice providers are presented on the following table along with 2023 patients served by county.

Patients Served by Hospice and County (Licensed and Unlicensed) Fiscal Year 2023							
State ID	**Hospice Agency**	**Bradley**	**Hamilton**	**Marion**	**Polk**	**Sequatchie**	**Total**
06063/06613	Adoration Home Health and Hospice Care East TN	83	154	38	21	11	307
06603	Kindred Hospice	52	128	NL	8	NL	188
19694	Avalon Hospice	2	129	18	0	3	152
33603	Amedisys Hospice an Adventa Co	77	502	48	47	26	700
33643	Gentiva	0	22	1	0	0	23
33653	Caris Healthcare	25	42	3	13	13	96
33673	Hearth Hospice of Tennessee	293	1,114	56	32	26	1,521
33613	Hospice of Chattanooga Inc	388	1,825	123	51	77	2,464
47602	Amedisys Hospice an Adventa Co	0	4	NL	1	0	5
	TOTAL PATIENTS	**920**	**3,920**	**287**	**173**	**156**	**5,456**

Source: Fiscal Year 2023 Hospice Master File; List of Agencies provided by TN Department of Health Licensure 5/14/2024.
NL = Not Licensed in that County. Note, these exclude any admissions by residential hospices from these counties.

No existing Service Area provider refers to unique Jewish programs, services and outreach as part of any collateral material, social media or other such outreach mechanism. Accordingly, it is Shalom Hospice's confirmed position supported by constituents throughout the area, that no existing hospice in the Service Area provides unique Jewish hospice services or any of the special initiatives that Shalom Hospice will introduce to this market. In fact, of the 9 licensed in-home hospice agencies in the five-county area, not a single hospice agency places an emphasis on serving the terminally-ill Jewish residents of Bradley, Hamilton, Marion, Polk and Sequatchie Counties. No other agency is accredited by NIJH.

The next table summarizes patients served by in-home agency for each of the last three years. In 2021 there were 5,370 in-home hospice admissions; admissions grew just 1.6 percent to 5,456 in 2023.

Patients Served by Hospice and County (Licensed and Unlicensed) Fiscal Years 2021 through 2023						
State ID	**Hospice Agency**	**2021**	**2022**	**2023**	**Change**	**% Change**
06063/06613	Adoration Home Health and Hospice Care East TN	199	637	307	108	54.3%
06603	Kindred Hospice	267	214	188	-79	-29.6%
19694	Avalon Hospice	213	234	152	-61	-28.6%
33603	Amedisys Hospice an Adventa Co	503	810	700	197	39.2%
33643	Gentiva	25	15	23	-2	-8.0%
33653	Caris Healthcare	90	74	96	6	6.7%
33673	Hearth Hospice of Tennessee	1,237	1,299	1,521	284	23.0%
33613	Hospice of Chattanooga Inc	2,836	1,973	2,464	-372	-13.1%
47602	Amedisys Hospice an Adventa Co	0	0	5	5	--
	TOTAL PATIENTS	**5,370**	**5,256**	**5,456**	**86**	**1.6%**

Source: Fiscal Year 2021 - 2023 Hospice Master File; List of Agencies provided by TN Department of Health Licensure 5/14/2024

Hospice of Chattanooga (33613) based in Hamilton County has the largest hospice program in the Service Area; however, in the past few years it was acquired by an investor group. Since that time its admissions have decreased 13 percent. The second largest program, Hearth Hospice (33673) increased its admissions by 284 and Amedisys (33603), the third largest program, increased its admissions by 197. Each of these are based in Hamilton County. The remainder of the programs admit 307 or fewer Service Area admissions each year. Review of provider websites indicates no reference to Jewish hospice services or unique initiatives for this special population. None of these hospice agencies nor any in the above table are accredited by the National Institute for Jewish Hospice like Shalom Hospice will be.

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

Given Shalom Hospice's specially tailored hospice program that will place an emphasis on serving Jewish terminally ill patients 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:

Shalom Hospice of Southeast Tennessee 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 Affinity Health affiliates operate 21 affiliate hospice programs with 27 offices across 12 states including Tennessee, Georgia, Florida, Washington, New Jersey, Virginia, Ohio, Indiana, Missouri, Maine, Oklahoma, Pennsylvania and Washington, D.C. The Tennessee, Manatee (FL), Sarasota (FL) and Washington D.C. approvals were each based on special circumstances serving underserved population groups. Each of the agencies are affiliated to one another, through common ownership (Samuel Stern and his trust), leadership, mission, values and common quality goals. Because Affinity Health is a privately owned company, it can quickly respond to individual market needs. Licensed Affinity Health affiliate programs are presented in the following chart:

Affiliated Hospice Programs
As of June 2024

Hospice Program	Main Office Location	Counties Served
Shalom Hospice LLC	Brentwood, TN	Davidson, Williamson and Rutherford Counties
Shalom Hospice of Greater Knoxville LLC	Knoxville, TN	Knox, Anderson, Blount, Loudon, Sevier and Jefferson Counties
Continuum Care of Broward LLC	Sunrise, FL	Broward County
Continuum Care of Sarasota LLC	Sarasota, FL	Sarasota County
Continuum Care of Miami Dade LLC	Miami, FL	Miami-Dade and Monroe Counties
Affinity Care of Manatee LLC	Bradenton, FL	Manatee County
Affinity Care of Charlotte and Desoto LLC	Port Charlotte, FL	Charlotte and DeSoto Counties
Continuum Care of Snohomish LLC	Everett, Snohomish County, WA	Snohomish and Pierce Counties
Continuum Care of King LLC	Federal Way, WA	King County
Affinity Care of New Jersey	Brick, Ocean County, NJ	Entire State of New Jersey
Affinity Care of Virginia	Newport News, Warwick County, VA	Entire State of Virginia
Affinity Care of Ohio	West Chester, OH	Cincinnati Area
Affinity Care of Northern Ohio	Munroe Falls, OH	Akron Area
Affinity Care of Indiana LLC	Indianapolis, IN	Entire State of Indiana
Affinity Care of Pennsylvania LLC	Trevose, PA	Philadelphia, Bucks, Montgomery, Delaware, Chester, Northampton, Lehigh, Monroe, Carbon and Schuylkill Counties
Affinity Care of Missouri LLC d/b/a One Community Hospice	Kansas City, MO	Platte, Clinton, Clay, Ray, Jackson, Lafayette, Cass and Johnson Counties
Affinity Care of DC LLC	Washington, DC	All of DC
Affinity Care of Maine LLC	Portland, ME	All of Maine
Affinity Care of Oklahoma LLC	Oklahoma, OK	All of Oklahoma
Affinity Care of Georgia LLC	Atlanta, GA	Dekalb, Cobb, Fulton, Cherokee, Henry, Butts, Rockdale, Clayton, Bartow and Barrow Counties
Affinity Care of Connecticut LLC	Hamden, CT	All of Connecticut

Quantifiable need for this project is derived from the analysis of the Jewish population in the Service Area, meetings with various constituents and the letters of support that identify the void that exists today of a Jewish hospice agency in the Service Area. In addition to information gathered during meetings, these letters specifically speak to the need for a faith based end of life provider knowledgeable and experienced in providing personalized and culturally sensitive care within the framework of Jewish law and ritual, within Bradley, Hamilton, Marion, Polk and Sequatchie Counties. The outpouring of support for the project is representative of Service Area physicians, rabbis and Jewish congregations, the Jewish community, assisted living facilities and nursing homes. The list of letter sponsors is presented below.

Physicians, Providers, Nursing Homes, Assisted Living Facilities and Home Health Agencies:

- Thomas Devlin, MD, PhD, FSVIN, CHI Memorial Neuroscience Institute, Director, Chattanooga Center for Neurologic Research LLC, Director, Neuroscience Innovation Foundation, Medical Director, CommonSpirit National Neuroscience Collaborative, Co-Director and Professor of Neurology, University of Tennessee Health Science Center
- Stephen V. Dreskin, MD, Tennessee Valley Pain Management
- Israel Franco, MD, Erlanger Urology
- Martin Simms, MD and Shelley Simms
- Karen E Hulley ACNP-BP, MSN, CCRN
- Ray Allen, Administrator, Soddy-Daisy Healthcare Center (Hamilton County)
- Lydia Sandberg, Director of Social Services, Life Care Center of Cleveland (Bradley County)
- Margaret Ferguson, Chaplain, Alexian Village Health and Rehabilitation Center (Hamilton County)
- Alicia Condra, Director of Nursing, Valley View Assisted Living (only ALF in Marion County)
- Bebe Kennedy, VP of Clinical Services, Morning Point Senior Living on behalf of its six area facilities:
    - Morning Pointe of Chattanooga
    - Morning Pointe of Collegedale at Greenbriar Cove
    - Morning Pointe of Hixson
    - Morning Pointe of Chattanooga at Shallowford
    - Morning Pointe of East Hamilton
    - The Lantern at Morning Pointe
- Ian Shives, Senior Executive Director, East Hamilton Morning Pointe (Hamilton County)
- Tess Greer, LPN, Wellness Director, Dominion Senior Living (Hamilton County)
- Sharon Scott, Resident Care Director, Regency House (Hamilton County)
- Rachel Southerland, RN, Health and Wellness Director, Brookdale Mount Vernon (Bradley County)
- Bill Tobin, Client Care Manager, Preferred Care at Home
- Savannah Burkhart, General Manager, Home Instead

Jewish Congregations and Religious Affiliated Organizations/Persons:

- Rabbi Shaul Perlstein, Chabad of Chattanooga
- Rabbi Sam Rotenberg, Rabbi at B'nai Zion Congregation
- Charles “Chuck” J. Fleischmann, Member of Congress, Tennessee Third District
- Kevin M. Spiegel, FACHE, Former CEO Erlanger Health System and Assistant Professor of Medicine, UT, Current Assistant Professor Drexel College of Medicine, President & CEO Medical Expansion Partners, Chaplain, United States Chaplain Corps
- Sarah Aronson, 911 Ambulance Driver and Jewish Burial Society
- Thomas P. Balazs, Professor – University of Tennessee, Chattanooga and Advisor, Jew-TC
- Manuel V. Mendizabal, AWR Ambassador, General Conference of Seventh Day Adventist Church Emeritus Ordained Minister, Southern Union Conference of Seventh Day Adventist Church
- Stonewall “Stoney” Ponders, Founder, Ponder Funeral Homes

Unaffiliated Community Support:

- Christine Duncan, Marion County resident
- Zachary Summit, Marion County resident

Demonstrating substantial market need as expressed by the region's assisted living facilities, 44 percent of Hamilton County's 18 assisted living facilities have provided letters of support with some quantifying their referrals. 100 percent of Marion County's assisted living facilities as there is only one – supports Shalom Hospice. Bradley County has 7 assisted living facilities; one has provided its support Shalom Hospice as of this date. Of note, there are no assisted living facilities in Polk or Sequatchie Counties. In aggregate, 10 of the 26 Service Area assisted living facilities, or 38 percent, have already voiced support for Shalom Hospice.

With respect to nursing homes, there are 17 in the five-county service area. Three have provided support at this early stage, which includes one-third of the Bradley nursing homes and 18 percent of Hamilton County providing support for Shalom Hospice. In aggregate, these facilities represent 18 percent of the Service Area facilities to date.

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 Shalom Hospice, others did in fact estimate the number of referrals to Shalom Hospice. These quantifiable estimates are identified below and in aggregate range between 160 and 264 admissions per year. Qualitative need provides for incremental admissions beyond that which is quantified in these letters and is discussed throughout this CON application.

Thomas Devlin, MD, CHI Memorial Neuroscience Institute (Hamilton County)

> *"Please approve the Shalom Hospice CON application to provide end of life hospice services to my Jewish patients, the Jewish population throughout southeast Tennessee and others who will benefit from its spiritual programming. I would estimate that in any given month, we would identify between 1 and 5 patients or families who would benefit…"*

Stephen V. Dreskin, MD, Tennessee Valley Pain Management

> *"Given the uniqueness of this program, I am confident it will be a community benefit for our patients and the public at large. I would anticipate with the size of our practice, that we would identify between 1 and 4 patients per month, depending on the month, who might consider this hospice program…."*

Ray Allen, Administrator, Soddy-Daisy Healthcare Center (Hamilton County)

> *"As the operator of Soddy Daisy Healthcare Center, I strongly advocate for the approval of a hospice in Southeast Tennessee that has an emphasis on serving Jewish patients. Based on Shalom Hospice's planned programming, and our resident profile, I would expect our facility and its physicians will refer an average of at least 2 patients per month to Shalom Hospice…"*

Lydia Sandberg, Director of Social Services, Life Care Center of Cleveland (Bradley County)

> *"Their rapid response to referrals will also be welcome 7 days per week. Based on our patients and knowledge of our community, I would anticipate referrals to Shalom Hospice will likely range between 2 and 3 per month..."*

Alicia Condra, Director of Nursing, Valley View Assisted Living – the only ALF in Marion County

> *"Shalom Hospice is seeking to meet some very specific underserved needs but will also admit any hospice appropriate patient that seeks its services, whether driven by its spiritual programming, service*

intensity or specialty programs. Each of these facets of its proposal are of interest to us as we believe our residents when appropriate for referral will benefit from rapid response, nearly daily patient touches, spiritual programming, music therapy and virtual reality. Given our resident profile, these referrals may number 1 to 3 per quarter.

Bebe Kennedy, VP of Clinical Services, Morning Point Senior Living on behalf of its six area facilities: Morning Pointe of Chattanooga, Morning Pointe of Collegedale at Greenbriar Cove, Morning Pointe of Hixson, Morning Pointe of Chattanooga at Shallowford, Morning Pointe of East Hamilton and The Lantern at Morning Pointe

" … Our reasons for this support are based on Shalom Hospice's referral response time, service intensity and spiritual programming. … With the above as Shalom Hospice's service commitment, we expect, based on our residents in our numerous facilities throughout this region, that each facility would likely have on average at least 1 referral per month. …"

Ian Shives, Senior Executive Director, East Hamilton Morning Pointe (Hamilton County)

"I was also impressed with their specialty programs of music therapy and virtual reality. These are unique programs they will offer to all patients at no cost regardless of funding. Given our resident profile and community, I would expect referrals to average 1 per month…"

Rachel Southerland, RN, Health and Wellness Director, Brookdale Mount Vernon (Bradley County)

". We are supportive of the HFC approving the Shalom Hospice application for several pertinent reasons which will benefit our Brookdale community. … With Shalom Hospice's service commitment as detailed above, we expect to refer at least one patient per month to Shalom Hospice. We strongly urge you to approve Shalom Hospice…"

Bill Tobin, Client Care Manager, Preferred Care at Home

"…Given the geographic footprint of the market we cover and the base of clients and families we serve, I anticipate that we would enjoy a mutual collaboration with Shalom Hospice as referring partners once they are granted licensure. I look forward to the Health Facilities Commission approving Shalom Hospice so that we may work with Shalom Hospice when that time comes.''

Savannah Burkhart, General Manager, Home Instead

"…Shalom Hospice's service intensity is unique and not currently available in our region. It will be of particular interest to our home care clients and their families. … Given our home care footprint and patients we are referred and/or admit, I would expect there to be mutual collaboration with Shalom Hospice including referral of appropriate patients on a regular basis…."

In addition to the above facility based providers who were able to shed light within their letters on the quantification of patients they would refer to Shalom Hospice, Rabbi Perlstein, Chabad of Chattanooga, indicates a substantial number of referrals. Bill Tobin, Preferred Care at Home indicates mutual collaboration and referring partners without quantifying the monthly referrals as did Savannah Burkhart with Home Instead. In addition, Sarah Aronson who is both a 911 ambulance provider and a member of the Jewish Burial Society, other rabbis and other organized Jewish leadership in the Service Area have conveyed their support for Shalom Hospice and the qualitative need for a Jewish hospice agency. Additionally, local physicians with Jewish patients have also conveyed their support for Shalom Hospice and its emphasis on serving persons of the Jewish faith. These latter groups are mostly based in Hamilton County but have constituents, congregants and/or patients from throughout the Service Area. Excerpts from some of these letters of support were presented in **Attachment 1N -2**, Community Linkage Plan. The letters in their entirety are included in **Attachment 1N-2**.

Projected Utilization

Based on the detailed analysis presented in Question 4N, and the resulting conclusions summarized above, Shalom Hospice forecasts to admit 79 patients in year one and 156 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), Shalom 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 Shalom Hospice that each will be available and provided.

Levels of Hospice to be Provided by Shalom 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

As noted, the Jewish community sought Shalom Hospice to bring its specialized Jewish hospice and programming to Southeast Tennessee. In response, Shalom Hospice conducted its Service Area assessment and determined there to be a need throughout the Service Area. Considerable support for Shalom Hospice was obtained from Jewish community leaders, religious organizations, assisted living and nursing home facilities, physicians and others. Based on this analysis, Shalom 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 Shalom 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 Shalom 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, community support, identification of the underserved Jewish population and quantified patient referrals from referral sources, the Applicant has projected the annual number of patients to be admitted during the first two years of operation which is provided below.

Forecasted Admissions by County, Patient Days and Average Length of Stay

	Year 1		Year 2	
Service Area County	**Admissions**	**% of Total**	**Admissions**	**% of Total**
Bradley	16	20.0%	31	20.0%
Hamilton	49	62.0%	97	62.0%
Marion	6	8.0%	12	8.0%
Polk	4	5.0%	8	5.0%
Sequatchie	4	5.0%	8	5.0%
Total, Admissions	79	100.0%	156	100.0%
Average Length of Stay	42.8	--	65.6	--
Patient Days	3,379	--	10,235	--

In terms of length of stay, Affinity Care affiliates operate at an average length of stay of approximately 72 days after two years of operation. Experience has indicated in years one and two, the average starts at approximately 42 to 43 days and increases to 66 days throughout the second year and achieves 72 days by the start of the third year. The above lengths of stay are computed based on admissions and patient days and therefore is a blend of short stay and long stay patients. In the initial year of operation, there are a couple of factors impacting the overall length of stay and causing it to be 42.8 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.

Forecasted Patients and Patient Days by Level of Care[9]

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	77	3,311	153	10,030	75	6,719	97.5%	202.9%
General Inpatient Care	1	34	2	102	1	69	97.5%	202.9%
Continuous Home Care	*	*	*	*	*	*	--	--
Respite Care	1	34	2	102	1	69	97.5%	202.9%
Total	79	3,379	156	10,235	77	6,856	97.5%	202.9%

(*) 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 there is no other Jewish hospice agency in the Service Area, and the demand that exists to support the physical, spiritual, and religious well being of the Jewish terminally-ill patients in the Service Area, the above projections are both reasonable and achievable.

[9] The CON Application, including patients, utilization projections and staffing only include the specifics of the hospice program. The palliative care program is identified within the CON Application as a program to be offered; however it is provided under a Medicare Part B number, separate from the hospice provider.

1C

Sample Hospice Service Contracts

Skilled Nursing Facilities

SHALOM HOSPICE HOSPICE-SKILLED NURSING FACILITY CONTRACT

THIS AGREEMENT is executed as of this May 12, 2024 and effective as of the May 12, 2024 by and between _____ with its principal place of business located at _____("Nursing Home"), and Shalom Hospice Of Southeast Tennessee 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 May 12, 2024.

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: SHALOM HOSPICE OF New Jersey, 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:

SHALOM HOSPICE OF NEW JERSEY, LLC

By:_____

Name: _____

Title: Executive Director

NURSING HOME:

_____

By:

_____

Name:

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 **$360.00** 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 **$766.00** 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.

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Shalom Hospice and Shalom Hospice of Greater Knoxville

Licenses

Board for Licensing Health Care Facilities

State of Tennessee

License No. 0000000626

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

SHALOM HOSPICE, LLC

to conduct and maintain a

Hospice SHALOM HOSPICE, LLC

Located at 5409 MARYLAND WAY, SUITE 212, BRENTWOOD

County of WILLIAMSON *, Tennessee.*

This license shall expire NOVEMBER 30 *,* 2023 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 1ST *day of* DECEMBER *,* 2022 *.*

By Jennifer L. Rothrock Esq
ASST. COMMISSIONER, HEALTH LICENSURE & REGULATION

By Morgan McDonald
COMMISSIONER

DCF120

510

State of Tennessee

License No. 0000000629

Health Facilities Commission

Board for Licensing Health Care Facilities

This is to certify that a license is hereby granted by the Health Facilities Commission to SHALOM HOSPICE OF GREATER KNOXVILLE, LLC to conduct and maintain a Hospice

SHALOM HOSPICE OF GREATER KNOXVILLE LLC

Located at 8351 E WALKER SPRINGS LANE, SUITE 402, KNOXVILLE

County of KNOX, Tennessee.

The license shall expire DECEMBER 26, 2024 and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable and shall be subject to revocation at any time by the Health Facilities Commission, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the Health Facilities Commission issued thereunder.

In Witness Whereof, we have hereunto set our hand and seal of the State this 9TH day FEBRUARY, 2024.

Health Facilities Commission

HFC

By Caroline R. Ogren, Esq., C.H.C.
Director, Licensure & Regulation

By
Executive Director

DCF 120

511

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Shalom Hospice and Shalom Hospice of Greater Knoxville

Deficiency Free Licensure Surveys

PRINTED: 11/02/2022
FORM APPROVED

Health Facilities Commission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN22036168	A. BUILDING: _____ B. WING _____	11/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALOM HOSPICE LLC	5409 MARYLAND WAY, SUITE 212 BRENTWOOD, TN 37027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	1200-8-27 Initial This Rule is met as evidenced by: An initial licensure survey conducted 11/1/2022. This agency meets the standards for Homecare Organizations providing Hospice Services. No deficiencies were cited.	H 001		

Health Facilities Commission
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

PRINTED: 12/14/2023
FORM APPROVED

Health Facilities Commission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL549629	A. BUILDING: _____ B. WING _____	12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALOM HOSPICE OF GREATER KNOXVILLE	8351 E WALKER SPRINGS LANE SUITE 402 KNOXVILLE, TN 37923

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	1200-8-27 Initial An initial licensure survey was completed on 12/13/2023 at Shalom Hospice of Greater Knoxville, LLC. The agency was found to be in compliance with the regulations at Chapter 0720-26 Standards For Home Care Organizations Providing Hospice Services.	H 001		

Health Facilities Commission
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

State of Tennessee
Health Facilities Commission
West Tennessee Regional Office
295 Summar Drive, 2nd Floor, Jackson, Tennessee 38301
www.tn.gov/hsda Phone: 731-984-9684 Fax: 731-427-0407

November 10, 2022

Leslie Baker Smith, Administrator
Shalom Hospice
5409 Maryland Way, Suite 212
Brentwood, TN 37027

Via Email: lbaker@shalomtn.com

RE: Licensure Health Survey TNP22036168

Dear Ms. Smith:

We are pleased to inform you that no deficiencies were cited as a result of the initial health licensure survey completed at your facility on 11/1/2022. A copy of the survey is enclosed for your records.

Thank you for your cooperation during these surveys. If this office can be of assistance to you in any way, please do not hesitate to contact us.

Sincerely,

Rhonda Rogers/cl
Public Health Nurse Consultant 2

RR/cl

Enclosure(s)

5C - 3

Shalom Hospice and Shalom Hospice of Greater Knoxville

CHAP Accreditation and Deficiency Free Surveys

CHAP Community Health Accreditation Partner

04/29/2024

JENNIFER WONDOLOWSKI
VP SPECIAL SERVICES
AFFINITY HEALTH MANAGEMENT LLC
140 LITTLETON ROAD, STE 103
PARSIPPANY, NJ 07054-1867

RE:

Customer ID:	3001532
Service:	Hospice [Deemed]
CCN/PTAN:	Pending

Location and/or Site Accredited:
SHALOM HOSPICE OF GREATER KNOXVILLE LLC
8351 E. WALKER SPRINGS LANE, SUITE 402
KNOXVILLE, TN 37923

Site Visit Dates:	04/09/2024 - 04/11/2024
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	N/A
CHAP Accreditation Dates:	04/11/2024 - 04/11/2027
Method of Follow-up:	N/A

Dear JENNIFER WONDOLOWSKI,

I am pleased to inform you that based on the findings of the site visit conducted 04/09/2024 - 04/11/2024, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

Should you wish to appeal, please email your Director of Accreditation, Linda Woodle, with the details of your appeal request within the next 10 days of notification receipt.

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

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour, RN, MBA, MHA
Chief Operating Officer

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701 | Fax: 202.862.3419
Teresa.Harbour@chapinc.org | www.chapinc.org

ID: *APR0924_GZB*
Ref: *PAXX629226*

CHAP Community Health Accreditation Partner

02/28/2023

Mr. Sam Stern
CEO
Continuum Care of Snohomish LLC
1000 SE Everett Mall Way, Suite 402
Everett, WA 98208

RE:	Customer ID:	3001532
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Shalom Hospice LLC
5409 Maryland Way Ste 212
Brentwood, TN 37027-5068

Site Visit Dates:	02/01/2023 - 02/03/2023
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	N/A
Effective Date of Accreditation:	02/03/2023
Expiration Date of Accreditation:	02/03/2026
Method of Follow-up:	N/A

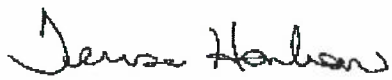
Dear Mr. Stern,

I am pleased to inform you that based on the findings of the site visit conducted 02/01/2023 - 02/03/2023, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,



Teresa Harbour, RN, MBA, MHA
Chief Operating Officer

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701 | Fax: 202.862.3419
Teresa.Harbour@chapinc.org | www.chapinc.org

CC: CMS Regional Office (CMS RO IV - Atlanta)
CMS Central Office
State Agency

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0379

HOSPICE SURVEY AND DEFICIENCIES REPORT

CERTIFICATION NUMBER	NAME OF FACILITY	SURVEY DATE
	Shalom Hospice LLC	2/3/2023

1. Was this hospice surveyed for compliance with 42 CFR 418.110? L50
☐ Yes ☒ No

2. If this hospice provides inpatient care directly, is the inpatient care provided on the premises? L51
☐ Yes ☒ No

3. Has a waiver of core nursing services been granted? L52
☐ Yes ☒ No

4. If "Yes" indicate date L53

5. Indicate type of setting(s) in which the hospice provides routine home care. L54
☑ Private residence ☑ SNF ☑ NF ☑ Other (specify) group home

6. Number of hospice patients residing in a SNF, NF or other residential facility who receive routine home care from the hospice. L55
2

7. Number of hospice patients admitted during recent 12 month period. L56
9

8. Number of records reviewed during survey. L57
9

9. Number of home visits conducted to patients in a private residence. L58
1

10. Number of home visits conducted to patients in residential facilities. L59
2

11. Does this hospice operate under the same certification number at more than one location? L60
☐ Yes ☒ No

12. If "Yes" enter number of locations. L61

13. Does this hospice operate as part of another entity that participates in the Medicare program? L62
☐ Yes ☒ No

14. If "Yes" enter the Medicare certification number of the entity. L63

SURVEYOR SIGNATURE	TITLE	DATE
Stephanie Wilson RN, BSN	CHAP Site Visitor	2/3/2023

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0379. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

HOSPICE SURVEY AND DEFICIENCIES REPORT

DEFICIENCIES

DATA TAG NUMBER	COP/STND. NO.	COMMENTS

I certify that I have reviewed each hospice Condition of Participation and related standards and except as indicated on this form the facility was found to be in compliance with the standards and/or the Conditions of Participation.

SURVEYOR SIGNATURE	TITLE	DATE
Stephanie Wilson RN, BSN	CHAP Site Visitor	2/3/2023
SURVEYOR SIGNATURE	TITLE	DATE

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:

Because there is currently no hospice agency in the Service Area that specifically serves the Jewish population, Shalom Hospice will have several positive effects on competition with regard to the healthcare system and positive impact in terms of consumer choice for services. At the very core, Shalom Hospice will provide Jewish terminally-ill patients and their loved ones with an option to choose a hospice agency that specializes in the diverse needs of Jewish patients and their families in a caring, dignified manner, consistent with Jewish heritage and values. This satisfies Consumer Advantage, Choice.

The Jewish Community in Southeast Tennessee currently have the following services to meet various life stage needs:

- Three Synagogues
  - Chabad Jewish Center of Chattanooga
  - B'nai Zion Congregation
  - Mizpah Congregation
- Jewish Federation of Greater Chattanooga
- Jewish Cultural Center
- Jewish Burial Society
- Aleph Bet Jewish Preschool
- Hadassah Chattanooga Chapter
- Jews – TC, a student organization of the University of Tennessee - Chattanooga

While each of the above resources are available with Jewish residents of the region actively participating, the area lacks a Jewish hospice agency. The Applicant will fill a void in service thereby enhancing accessibility and availability of Jewish hospice services for the Jewish terminally-ill throughout the Service Area. Under Jewish rituals, the returning of one's soul to God at the end of its journey in this world is the most profound moment in a person's life. As the soul approaches eternal life in heaven, religion becomes a source of comfort and peace. Because the existing hospice agencies are not familiar with Jewish rituals and customs, they are unable to ease the spiritual anguish of the dying and their families. Shalom Hospice will fill that void in this Southeast Tennessee area as it now does in Middle Tennessee and the Greater Knoxville area.

Shalom Hospice will become the first NIJH Accredited hospice agency in Southeast Tennessee to achieve this recognition. It will employ a Jewish Rabbi to serve as its chaplain, one that will incorporate Jewish ritual, faith, laws and customs and encourage the patient to reflect on their life, pass on wisdom, and make amends. The social worker(s) to serve on Shalom Hospice's team will understand and have knowledge of the Jewish Resources that are available during the end of life. All Shalom Hospice team members, including nurses, will be educated on all NIJH accreditation facets, in addition to traditions, rituals and other factors important to persons of the Jewish faith in end of life care.

Shalom Hospice will enhance access in this market through providing consumers with an alternative choice to meet their end of life in-home hospice needs. Aside from its Jewish initiative, the Applicant will promote quality through its service intensity which exceeds NHPCO minimum requirements. Its service intensity provides significant patient touches on a daily/weekly basis for its patients. This results in enhancement of quality of care with consumer advantage in mind. This is a true demonstration of how Shalom Hospice will favorably impact quality of care and cost effectiveness, and will be a distinct consumer advantage.

Shalom Hospice will offer an array of unique programs and services that go above and beyond what is covered by private insurance, Medicare and Medicaid. Further, these programs and services will provide consumers with additional services not generally available in the Service Area. They include but are not limited to:

- Virtual Reality Therapy (including the Jewish virtual reality experience in addition to other experiences)
- Equine Therapy
- Music Therapy
- Staffing levels that exceed NHPCO's guidance for hospice home care teams
- Continuum Palliative Resources

Virtual Reality, Equine Therapy, Music Therapy and Staffing Levels will be offered to all patients, regardless of payor source or availability of funds (including indigent patients). Palliative care is for non-hospice patients and will be initiated within six months of receiving Shalom Hospice's Medicare certification. This latter program is a Medicare Part B outpatient service that is available to all patients prior to electing hospice. It will be an affiliated provider; its staffing, visits and revenues are not shown in this CON Application as it is not a CON service nor will it be provided by Shalom Hospice of Southeast Tennessee. Each of these programs and services were described in **Attachment 1N** of this CON Application.

The approval of Shalom 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, Shalom Hospice's introduction will have no impact on consumer charges while offering additional services 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:

Shalom Hospice is confident there are available and accessible clinical professionals and support staff in the Service Area to adequately staff its hospice agency. This includes registered nurses. According to Tennessee.gov, in 2023 there were 9,506 registered nurses residing in the Service Area. The 2023 inventory of registered nurses is greater than the prior year of 9,300 RNs and two years prior of 9,105 RNs. The Service Area had a 4.4 percent growth in nurse inventory in the last two years with Hamilton incurring 238 additional RNs of the total 401, and each of the other counties incurring between 3 and 127 additional RNs. The growth in RN inventory within the Service Area is illustrated next.

Registered RN Inventory in Shalom Hospice Service Area				
2021 through 2023				
County	**2021**	**2022**	**2023**	**2-Year Change**
Bradley	1,501	1,567	1,628	8.5%
Hamilton	6,843	6,941	7,081	3.5%
Marion	370	389	390	5.4%
Polk	209	218	222	6.2%
Sequatchie	182	185	185	1.6%
Total	9,105	9,300	9,506	4.4%

Source: https://tnmap.tn.gov/health/nursing; accessed July 5, 2024.

REVISED 41R

Shalom Hospice of Southeast Tennessee will have its own Administrator who will office in Hamilton County. This will be a separate and distinct administrator from the other Shalom Hospice administrators within Tennessee.

With respect to therapy services, these will be available as needed by Shalom Hospice patients. However, these will not be employees as their utilization is expected to be minimal. Accordingly, they will be provided through a contracted third party when needed.

Shalom Hospice affiliates have significant operational success in its existing markets in recruiting and retaining qualified professionals. This is due in large part to its quality programming, service intensity in the hospice industry and the significant community linkages it establishes across the healthcare continuum and educational institutions. Another unique feature of Shalom Hospice affiliates is the travel program it has developed within its organization to enable nurses and others who are employed to volunteer to be temporarily or permanently placed in other service areas to meet the patients' needs of affiliate offices while accommodating employees' interests in relocation.

Evidence of successful integration into the Greater Chattanooga area and Southeast Tennessee healthcare community is demonstrated by the fact that Shalom Hospice has only just entered this region of the state with its proposal. Yet, it has obtained support for this initiative from many nursing homes and assisted living facilities which are longstanding healthcare providers throughout the area. Specifically, approximately 30 percent of these facilities throughout the Service Area provided letters of support. This includes 20 percent of facilities in Bradley County, 34 percent of those in Hamilton County and 50 percent of those in Marion County. It also includes the only ALF in Marion County. Further, it has garnered support from area physicians, including CHI Memorial's Dr. Devlin, Erlanger Urology's Dr. Franco, Tennessee Valley Pain Management's Dr. Dreskin, other providers, religious leaders and numerous other community representatives.

Accordingly, Shalom Hospice will use these and other venues to recruit qualified, competent staff needed to provide safe and effective care to the hospice eligible Jewish and other population residing within this Service Area. The Applicant's staffing model demonstrates that the Applicant will far exceed general staffing guidelines and qualifications set forth by the National Hospice and Palliative Care Organization (NHPCO).

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/Licensure Division

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 60 days of licensure. The Applicant will also seek accreditation from the National Institute for Jewish Hospice as soon as it meets the criteria to become accredited. It expects to achieve accreditation as soon as allowable after receiving its license.

Shalom Hospice in Middle Tennessee was licensed on November 30, 2023; its license is included in **Attachment 5C-1.** This was a deficiency free survey as evidenced by the letter from the Health Facilities Commission included in **Attachment 5C-2.**

Approximately 60 days later, on February 1 to 3, 2023, it received its CHAP accreditation after a deficiency free survey. Subsequently, also in February 2023, it received its NIJH accreditation. Its NIJH accreditation certificate is included in **Attachment 4N**; its CHAP accreditation approval letter and deficiency free CHAP results are

included in **Attachment 5C-3**. Additionally, as of May 1, 2023, Shalom Hospice received its TennCare provider number and now contracts with the TennCare managed care plans in Middle Tennessee.

Shalom Hospice of Greater Knoxville was licensed in late December 2023; its license is included in **Attachment 5C-1.** This was a deficiency free survey as evidenced by the letter from the Health Facilities Commission included in **Attachment 5C-2.**

Approximately 100 days later, on April 11, 2024, it received its CHAP accreditation after a deficiency free survey. It actually received it NIJH accreditation shortly after licensure, and before Medicare certification (January 2024). Its NIJH accreditation certificate is included in **Attachment 4N**; its CHAP accreditation approval letter and deficiency free CHAP results are included in **Attachment 5C-3**. As of June 26, 2024, despite it having a deficiency free CHAP/Medicare survey in April, it is still awaiting its Medicare provider number due to a processing error at the intermediary. Once that is received, it will apply for its TennCare provider number and subsequently initiate contracts with the TennCare managed care plans in Southeast Tennessee.

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.

	Hospice Patients Served			Total Hospice Deaths*			Hospice Penetration Rate	Hospice Penetration Rate and Patient	
County Name	2021	2022	Mean	2021	2022	Mean	Mean Number of Patients/ Mean Number of Deaths	(Median Rate)*80 %	(Median Rate)*85 %
								0.443	0.471
Anderson	776	989	883	1,139	1,070	1,105	0.799	(393)	(363)
Bedford	324	316	320	600	522	561	0.570	(71)	(56)
Benton	120	122	121	310	240	275	0.440	1	8
Bledsoe	90	95	93	166	141	154	0.603	(24)	(20)
Blount	932	1065	999	1,751	1,773	1,762	0.567	(218)	(169)
Bradley	890	1010	950	1,481	1,260	1,371	0.693	(343)	(305)
Campbell	360	396	378	715	645	680	0.556	(77)	(58)
Cannon	82	69	76	192	188	190	0.397	9	14
Carroll	252	256	254	452	454	453	0.561	(53)	(41)
Carter	416	687	552	905	832	869	0.635	(167)	(143)
Cheatham	234	232	233	509	440	475	0.491	(23)	(10)
Chester	88	90	89	248	210	229	0.389	12	19
Claiborne	279	364	322	563	468	516	0.624	(93)	(79)
Clay	50	50	50	129	133	131	0.382	8	12
Cocke	379	430	405	680	693	687	0.589	(100)	(81)
Coffee	451	477	464	808	826	817	0.568	(102)	(79)
Crockett	80	95	88	203	197	200	0.438	1	7
Cumberland	470	437	454	1,152	1,005	1,079	0.420	24	54
Davidson	3083	3008	3,046	5,457	5,055	5,256	0.579	(717)	(571)
Decatur	110	110	110	205	178	192	0.574	(25)	(20)
DeKalb	119	131	125	302	264	283	0.442	0	8
Dickson	414	408	411	688	622	655	0.627	(121)	(103)
Dyer	241	329	285	591	509	550	0.518	(41)	(26)
Fayette	156	132	144	518	522	520	0.277	86	101
Fentress	110	118	114	352	292	322	0.354	29	38
Franklin	341	359	350	613	591	602	0.581	(83)	(67)
Gibson	321	424	373	848	750	799	0.466	(19)	4
Giles	321	269	295	491	438	465	0.635	(89)	(76)
Grainger	209	201	205	352	322	337	0.608	(56)	(46)
Greene	695	985	840	1,172	1,056	1,114	0.754	(346)	(316)
Grundy	126	149	138	225	219	222	0.619	(39)	(33)
Hamblen	625	634	630	1,049	910	980	0.643	(196)	(168)
Hamilton	3961	3524	3,743	4,163	3,888	4,026	0.930	(1,959)	(1,848)
Hancock	54	51	53	120	112	116	0.453	(1)	2
Hardeman	164	176	170	355	366	361	0.472	(10)	(0)
Hardin	282	288	285	484	422	453	0.629	(84)	(72)
Hawkins	406	615	511	984	944	964	0.530	(83)	(57)

NOTE: In the Hospice Death definition infant mortality cannot simply be added to the other cause factors, as infant mortality constitutes any death of persons 365 days or younger, regardless of cause. Infant mortality is NOT a separate cause of death category, similar to suicide, homicide, or accidents. Some of the causes for infant death will include accidents and homicides. Therefore, there is some overlap between infant deaths and accidents and homicides. IF Vital Statistics rate sheets are used to calculate Hospice-defined deaths, then it should be noted that there may be a few infant deaths also counted in accidents and homicides. HOWEVER, since the number of deaths that fall under both infant death and homicide or accident are relatively small, the tables may still function to establish need (or lack thereof) for Hospice; though it is dependent on Licensure's discretion.

Hospice Death - *all deaths minus all accidents, suicides, homicides and infant deaths where infants did not die of accidents or homicide in the same given time period (in this case, one calendar year)*

~Per the Tennessee State Health Plan

Haywood	95	117	106	273	235	254	0.417	7	14
Henderson	181	188	185	412	407	410	0.451	(3)	8
Henry	248	327	288	535	533	534	0.538	(51)	(36)
Hickman	162	156	159	322	367	345	0.462	(6)	3
Houston	54	91	73	132	105	119	0.612	(20)	(17)
Humphreys	156	155	156	314	241	278	0.560	(33)	(25)
Jackson	62	61	62	164	199	182	0.339	19	24
Jefferson	526	775	651	830	756	793	0.820	(299)	(277)
Johnson	117	184	151	272	275	274	0.550	(29)	(22)
Knox	3262	4078	3,670	5,073	4,910	4,992	0.735	(1,459)	(1,320)
Lake	29	36	33	131	89	110	0.295	16	19
Lauderdale	139	151	145	345	306	326	0.445	(1)	8
Lawrence	486	468	477	651	652	652	0.732	(188)	(170)
Lewis	105	106	106	203	178	191	0.554	(21)	(16)
Lincoln	285	258	272	520	502	511	0.531	(45)	(31)
Loudon	461	606	534	756	818	787	0.678	(185)	(163)
McMinn	552	585	569	873	771	822	0.692	(204)	(182)
McNairy	157	235	196	419	451	435	0.451	(3)	9
Macon	67	110	89	310	322	316	0.280	52	60
Madison	529	682	606	1,197	1,118	1,158	0.523	(93)	(61)
Marion	265	329	297	440	423	432	0.688	(106)	(94)
Marshall	266	252	259	429	367	398	0.651	(83)	(72)
Maury	949	1,136	1,043	1,104	1,099	1,102	0.946	(554)	(524)
Meigs	137	153	145	195	206	201	0.723	(56)	(51)
Monroe	331	371	351	749	669	709	0.495	(37)	(17)
Montgomery	663	1,005	834	1,705	1,544	1,625	0.513	(114)	(69)
Moore	29	36	33	89	77	83	0.392	4	7
Morgan	116	162	139	307	307	307	0.453	(3)	6
Obion	182	218	200	471	439	455	0.440	2	14
Overton	152	153	153	373	330	352	0.434	3	13
Perry	63	64	64	135	103	119	0.534	(11)	(7)
Pickett	21	17	19	71	98	85	0.225	18	21
Polk	167	181	174	321	276	299	0.583	(42)	(33)
Putnam	420	467	444	975	877	926	0.479	(33)	(8)
Rhea	364	457	411	523	471	497	0.826	(190)	(177)
Roane	427	546	487	842	757	800	0.609	(132)	(110)
Robertson	433	523	478	874	853	864	0.554	(95)	(72)
Rutherford	1355	1467	1,411	2,582	2,319	2,451	0.576	(325)	(257)
Scott	140	170	155	357	299	328	0.473	(10)	(1)
Sequatchie	138	220	179	213	179	196	0.913	(92)	(87)
Sevier	744	768	756	1,327	1,152	1,240	0.610	(207)	(173)
Shelby	4419	4367	4,393	9,618	8,312	8,965	0.490	(421)	(173)
Smith	91	145	118	254	253	254	0.465	(6)	1
Stewart	64	101	83	188	180	184	0.448	(1)	4
Sullivan	1749	2064	1,907	2,517	2,388	2,453	0.777	(820)	(752)

NOTE: In the Hospice Death definition infant mortality cannot simply be added to the other cause factors, as infant mortality constitutes any death of persons 365 days or younger, regardless of cause. Infant mortality is NOT a separate cause of death category, similar to suicide, homicide, or accidents. Some of the causes for infant death will include accidents and homicides. Therefore, there is some overlap between infant deaths and accidents and homicides. IF Vital Statistics rate sheets are used to calculate Hospice-defined deaths, then it should be noted that there may be a few infant deaths also counted in accidents and homicides. HOWEVER, since the number of deaths that fall under both infant death and homicide or accident are relatively small, the tables may still function to establish need (or lack thereof) for Hospice; though it is dependent on Licensure's discretion.

Hospice Death - *all deaths minus all accidents, suicides, homicides and infant deaths where infants did not die of accidents or homicide in the same given time period (in this case, one calendar year)*

~Per the Tennessee State Health Plan

Sumner	1207	1261	1,234	2,100	1,950	2,025	0.609	(337)	(281)
Tipton	244	234	239	734	735	735	0.325	86	107
Trousdale	58	69	64	136	98	117	0.543	(12)	(8)
Unicoi	201	309	255	352	312	332	0.768	(108)	(99)
Union	139	181	160	319	258	289	0.555	(32)	(24)
Van Buren	48	42	45	137	89	113	0.398	5	8
Warren	318	314	316	569	563	566	0.558	(65)	(50)
Washington	1100	1430	1,265	1,778	1,627	1,703	0.743	(511)	(464)
Wayne	137	131	134	248	246	247	0.543	(25)	(18)
Weakley	147	268	208	465	460	463	0.449	(3)	10
White	159	168	164	450	432	441	0.371	32	44
Williamson	1109	1143	1,126	1,515	1,530	1,523	0.740	(451)	(409)
Wilson	786	919	853	1,409	1,346	1,378	0.619	(242)	(204)
Unknown	0	0	0						
Tennessee	*45,022*	*50,301*	*47,662*	*81,575*	*75,416*	*78,496*	*0.607*	*(12,884)*	*(10,711)*

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. *Death Statistical System, 2018-2022. Nashville, Tennessee. 2021-2022 JAR Hospice (not including Residential Hospice) data used for patient data.*

***Certain deaths are excluded*:** Accidental (including motor vehicle accidents), homicide, suicide, and infant deaths. ICD-10 Codes excluded: V01-X60, X60-X84, X85-Y09, Y85-Y86, Y87.0-Y87.1

Attachment - Home Care Organizations

Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

[redacted]	Existing Licensed County	Parent Office County	Proposed Licensed County	[redacted]	Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	☐	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	✠	McMinn	☐	☐	☐
Campbell	☐	☐	☐	McNairy	☐	☐	☐
Cannon	☐	☐	☐	Macon	☐	☐	☐
Carroll	☐	☐	☐	Madison	☐	☐	☐
Carter	☐	☐	☐	Marion	☐	☐	✠
Cheatham	☐	☐	☐	Marshall	☐	☐	☐
Chester	☐	☐	☐	Maury	☐	☐	☐
Claiborne	☐	☐	☐	Meigs	☐	☐	☐
Clay	☐	☐	☐	Monroe	☐	☐	☐
Cocke	☐	☐	☐	Montgomery	☐	☐	☐
Coffee	☐	☐	☐	Moore	☐	☐	☐
Crockett	☐	☐	☐	Morgan	☐	☐	☐
Cumberland	☐	☐	☐	Obion	☐	☐	☐
Davidson	☐	☐	☐	Overton	☐	☐	☐
Decatur	☐	☐	☐	Perry	☐	☐	☐
DeKalb	☐	☐	☐	Pickett	☐	☐	☐
Dickson	☐	☐	☐	Polk	☐	☐	✠
Dyer	☐	☐	☐	Putnam	☐	☐	☐
Fayette	☐	☐	☐	Rhea	☐	☐	☐
Fentress	☐	☐	☐	Roane	☐	☐	☐
Franklin	☐	☐	☐	Robertson	☐	☐	☐
Gibson	☐	☐	☐	Rutherford	☐	☐	☐
Giles	☐	☐	☐	Scott	☐	☐	☐
Grainger	☐	☐	☐	Sequatchie	☐	☐	✠
Greene	☐	☐	☐	Sevier	☐	☐	☐
Grundy	☐	☐	☐	Shelby	☐	☐	☐
Hamblen	☐	☐	☐	Smith	☐	☐	☐
Hamilton	☐	☐	✠	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	☐	☐	☐				

Project Name : Shalom Hospice of Southeast Tennessee LLC

Supplemental Round Name : 1 **Due Date :** 7/10/2024
Certificate No. : CN2406-016 **Submitted Date :** 7/3/2024

1. **3A. Proof of Publication**

Please reattach a copy of the proof of publication as the attached copy is not legible.

Response : An additional copy provided by the Chattanooga Free Times Press is included in an updated Attachment 3A.

2. **7A. Type of Ownership of Control**

Please confirm that no other entities have ownership interests in the applicant.

Response : The only entities with an ownership interest in the Applicant are Samuel Stern (5%) and his trust, SYGS 2023 Trust (95%) as stated in response to questions 7A and 1E.

3. **9C. Other Facilities Charges**

Please include a footnote in the table on Page 20 of the application that State ID 33643 - Gentiva Hospice replaced Avalon Hospice in the table in the 2023 JAR.

Response : A footnote has been added to the table on page 20; the file has been resubmitted. It has also been added to the table on 1NR, page 30.

4. **8Q. Staffing**

Does the applicant plan to eventually staff nutritionist/dietitians or a volunteer coordinator?

Has the applicant identified a Medical Director? Will the Medical Director be covering this agency only, or will they also cover the applicant's affiliates in Middle and East TN?

What are the contractual staff positions for?

Response : The applicant will staff a volunteer coordinator once its average daily census reaches 40; prior to that the office assistant assumes that role. Via contract, Shalom will have a nutritionist/dietician available in accordance with Medicare Conditions of Participation. The costs associated with the nutritionist/dietician are incorporated in the applicant’s budget for ancillary services.

The Applicant has not yet identified a Medical Director. The Medical Director will be a physician in the Service Area who will work with Shalom Hospice under a contractual agreement. For its services on the IDT and quality plan, it will be paid a contractual fee. For its patient care services, those will be separate billings under the physician's provider number. The contractual staff identified in the staffing chart is the Medical Director's administrative role as part of the care team.

5. **4N. Special Needs of Service Area**

Which other applicant affiliates are NIJH accredited?

Response : The Applicant's affiliates in Middle Tennessee (Shalom Hospice, LLC), East Tennessee (Shalom Hospice of Greater Knoxville LLC) and its corporate office (Affinity Health Management) are each separately accredited by NIJH.

6. **5N. Unimplemented services**

Application Page 29 - "Patients Served by Hospice and County (Licensed and Unlicensed) Fiscal Year 2023": It appears that the following items are not correct:

Number of patients served by State ID - 06063/06613 Adoration Home Health and Hospice Care East TN and State ID - 06603 Kindred Hospice are incorrect for Polk County and for the Total column.

The number of Total Patients for all agencies (5,451 listed - should be 5,456).

Please revise and replace Attachment 5N, Page 29 (labeled as Attachment 5NR, Page 29R).

Response : Corrections to the two tables in Question 5N, page 29, have been made. 5NR has been attached to the CON application file and uploaded. See page 29R within 5NR.

7. **3C. Effects of Competition and/or Duplication**

It is noted on Page 41 that "Virtual Reality, Equine Therapy, Music Therapy and Staffing Levels will be offered to all patients, regardless of payor source or availability of funds (including indigent patients)."

Does this mean that there is no additional cost to patients for these programs, or that the programs will be provided for an additional fee to those patients who can afford it, and made available at no cost or reduced cost to patients who cannot afford it?

Response : There is no additional cost for these programs. The Applicant provides these additional services as part of its programming and does not charge additionally for these services, regardless of ability to pay.

8. **4C. Accessibility to Human Resources**

Attachment 4C, Page 41 "Registered RN Inventory in Shalom Hospice Service Area"

It appears that the number of RN's registered in 2023 results in slightly different results when staff attempted to verify the data presented for the following:

Hamilton County - 6,843 RNs

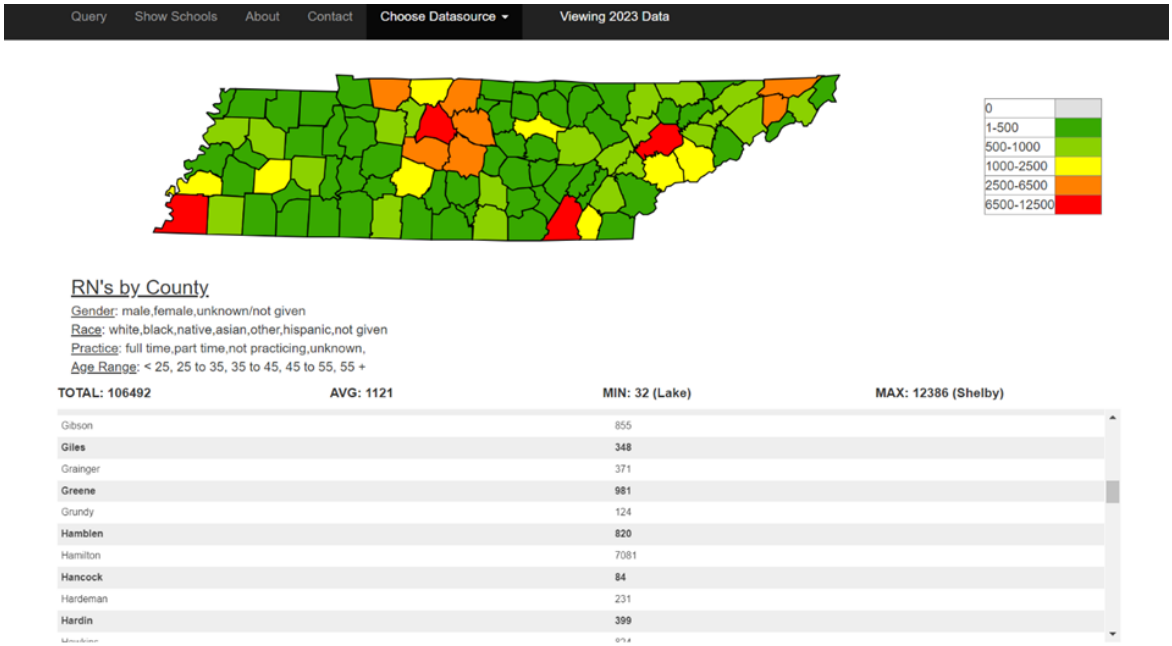
Bradley County - 1,628 RNs

Polk County - 222 RNs

Sequatchie County - 185 RNs

Please confirm and revise the table as necessary including the 2-Year Change Data (labeled as Attachment 4CR, Page 41R.)

Response : It would appear the table's data is dynamic and may include updates. A review of the table on July 5, 2024 indicates the revised counts for Polk, Sequatchie and Bradley Counties correspond with the above requested revisions. However, Hamilton County on this data now reflects 7,081 RNs in 2023. See screenshot below of this value taken on July 5, 2024.



The table in 4C has been updated with these revised values. 4C was provided as an attachment within the 3C, 4C and 5C PDF. This attachment has been updated and attached to the CON form as an upload.

9. **1N. Criteria and Standards**

Attachment 1N, Hospice Criterion #1. Adequate Staffing, Page 2

It is noted that "Approximately 12 percent of its admissions are patients who identify as Jewish; this contrasts with 1 percent of the population being Jewish."

Does the applicant project a similar percentage of Jewish patients will be represented within the proposed project service area?

Response : Currently the percent of patients who are Jewish at the Shalom Hospice of Greater Knoxville agency is 20 percent. This has increased from 15 percent in its first month of Medicare certification (April) to current admissions of approximately 25 percent (for an overall to-date average of approximately 20 percent). The Applicant believes the demographic composition of the Southeast Tennessee Jewish community is more akin to the Greater Knoxville area's Jewish community. It therefore expects that its Jewish admissions will represent at least 20 percent of its total admissions.

10. **1N. Criteria and Standards**

Attachment 1N, Hospice Criterion #1. Adequate Staffing, Page 5

What training is associated with direct service staff to obtain and maintain NIJH accreditation?

What role does the NIJH accreditation process play in evaluating whether clinical and non-clinical services are delivered in accordance with NIJH standards?

Is the Halachic Medical Directive included as Attachment 1N -17 related to the NIJH accreditation process?

Response : NIJH Accreditation includes annual training of staff members who interact with the patient and/or the patient's family. Training modules cover all aspects of Jewish Heritage & Holidays, Jewish Medical Ethics and The Final Journey — Death, Burial and Mourning. The goal through NIJH training is for the staff to gain enhanced understanding of Jewish culture and religion, and how it relates to death and dying. Participation in the annual NIJH Conference is one of the requirements for accreditation. The NIJH Conference features sessions on Jewish Medical Ethics, End-of-Life caring from a Jewish perspective, Jewish aspects of Consolation and Bereavement, caring for different groups within Judaism and other important topics. Before every Jewish holiday, NIJH provides an informational sheet about the holiday including historical background, holiday observances and possible hospice concerns. Additionally, through NIJH, staff has access to related articles, pamphlets, audio lectures including topics such as living will, Vidui and final processes at death.

NIJH does not evaluate clinical and non-clinical services nor conduct surveys of accredited hospices. However, with respect to Shalom Hospice, Mr. Stern as an Orthodox Jew and others in the Affinity organization conduct their own internal and ongoing performance reviews to assure that Shalom Hospice is compliant with Jewish rituals, traditions and cultures.

The Halachic Medical Directive is published by Chayim Aruchim, which is an organization distinct from NIJH. Chayim Aruchim's mission is dedicated to helping members of the Jewish community make end-of-life healthcare decisions in keeping with their religious beliefs. Chayim Aruchim has a team of medically trained Rabbis, doctors, legal experts, patient and pastoral care professionals. Shalom Hospice ascribes to Chayim Aruchim as part of its operation incorporating its recommendations and medical directive into its processes. Chayim Aruchim is voluntary and not a requirement of the NIJH accreditation.

11. **1N. Criteria and Standards**

Attachment 1N, Hospice Criterion #6 Quality Control and Monitoring, Page 37

Why are the FTEs 50% for the part time hospice aides in the table?

Have any of the applicant's existing affiliate hospices reached the 8.0 patients per hospice aide ratio referenced in response to this criterion?

Response : The staffing table in the JARs identifies full time and part time employees. The full time staff are defined as 1.0 FTEs. The part time staff denotes less than full time so could be a few hours per week up to less than 40 hours per week. Accordingly, we included all part time at an average of 20 hours per week, or 0.5 FTEs, or 50 percent as noted in the question. We believe this is a reasonable computation absent any additional information.

Through experience, Affinity has developed staffing metrics which meet the needs of its patients, maintaining them on the routine level of care, and avoiding unnecessary crisis care. These ratios have a positive effect on quality of care and cost effectiveness as they avoid more costly care. The ratio of 8 patients per hospice aide ratio is one of these staffing metrics. Specifically, with respect to 8 patients per aide ratio, it is the Affinity programming model to staff to that level to achieve the service intensity it promotes and utilizes throughout the company to assure daily touches with its patients. And, within both the Middle Tennessee and the Greater Knoxville area, the two Shalom affiliates are also staffing to that level.

12. **1N. Criteria and Standards**

Attachment 1N, Hospice Criterion #6 Quality Control and Monitoring, Page 44

Approximately how many patients are represented in these quality measures tables?

Only one, Continuum Care of Snohomish LLC appears to list an average daily census ADC on the Medicare Compare website and many appear to have been established in the past 3-5 years.

Response : In the quality measure tables provided in response to this criterion, the 2023 data reflects 5,755 patients. The Q1 2024 data table is reflective of 1,758 patients during this quarterly period.

13. **1N. Criteria and Standards**

Attachment 1N, Hospice Criterion #17 Need Formula, Page 50

There appears to be an error in the Hospice Projected Need Report Table on Page 50:

Sequatchie County - Hospice Penetration Rate, Need / Surplus @ 80% and Need / Surplus @ 85%.

Please revise and resubmit Attachment 1N - Page 50 (labeled as Attachment 1NR, Page 50R.)

Response : Attachment 1NR has been uploaded (and the prior 1N removed); the table on page 50 has been replaced with the correct entries for Sequatchie County.

14. **1N. Criteria and Standards**

Attachment 1N, Hospice Criterion #6 Quality Control and Monitoring, Page 35

It is noted that the applicant states the following "With respect to the National Palliative Care Registry for Hospice Projects, it is Shalom Hospice's intent to evaluate this registry for participation after CON approval and licensure"

Does the applicant participate in the National Palliative Care Registry for Hospice Projects at its other affiliate sites, and specifically its Tennessee-based hospice sites? If not, why has it chosen to decline participation?

Response : The National Palliative Care Registry for Hospice Projects is sponsored by PCQC (Palliative Care Quality Collaborative), an independent organization which collects outcome data about palliative care programs and their patients. Shalom Hospice has engaged with PCQC to enroll in its registry as an advanced tier participant. PCQC advises that the two Shalom affiliates in Tennessee will begin actively participating in the registry during Q3 2024. Provided Shalom Hospice confirms the importance of participation, Shalom Hospice expects that it will similarly include its Southeast Tennessee affiliate in registry participation.