

Access to care

Do religious and secular health care providers differentially affect access to health care services?

December 11, 2013

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EXECUTIVE SUMMARY

Religious health care organizations, including Providence Health Services, PeaceHealth and the Franciscan Health System, have recently acquired, merged or established formal affiliations with a number of hospitals in Washington state. These recent – as well as any proposed future – acquisitions, mergers and affiliations have become a source of concern for the American Civil Liberties Union (ACLU), supporters of our state’s Death with Dignity Act (DWD), and members of and families within the Lesbian/Gay/Bisexual/Transgender (LGBT) community.

In part, their concerns pertain to access to health care services that are outside the directives established by the U.S. Conference of Catholic Bishops. Such services include reproductive health care procedures like abortions and sterilizations, and end of life choices as prescribed within DWD. In addition, they are also concerned that LGBT families may potentially become subject to religiously-based discriminatory practices such as denied visitations to hospitalized same-sex spouses.

To address these concerns, we have assessed current practices using inpatient discharge data from all community hospitals within Washington; inpatient and outpatient utilization data on Medicaid enrollees; statewide and county-specific abortion and hospice data; and, DWD information. We have also reviewed the policies of the Department of Health (DOH) and the Centers for Medicare and Medicaid Services (CMS) regarding patient visitation rights as well as the policies and procedures regarding their complaint processes.

Our findings suggest that communities predominately served by religious hospitals do not appear to be experiencing barriers to care. On the contrary, tubal ligation sterilization rates within communities served by religious hospitals are the same as – or higher than – the rates within communities served by secular hospitals. And, within hospitals themselves, while the overall proportion of tubal ligations per birth is higher in secular hospitals, the proportion per C-sections is essentially the same or higher in religious hospitals.

No differences associated with hospitals’ religious or secular status were detected in community’s abortion rates, although few abortions are performed among inpatients. We did, however, see little concordance between county abortion rates and county unintended pregnancy rates; this suggested a high degree of complexity in assessing variations among counties and the likelihood that multiple factors affect a woman’s decision in choosing to have an abortion and in addressing an unintended pregnancy.

While DWD data was limited, no readily apparent differences associated with the religious status of the hospice care providers were found. Income may, however, be a factor since Medicare does not reimburse for the physician office visits required under DWD. In addition, we noted that the policies of all three religious health care systems explicitly prohibit participating in the patient choices as outlined within the DWD Act. We believe that additional monitoring of this situation may be warranted.

As for potential discriminatory practices against LGBT patients or their families, there have been no such instances reported to DOH over the last five years, and such practices are prohibited by CMS.

Overall, we believe a more comprehensive data system, such as an all-payer database, would be needed to more fully understand and assess the potential impacts of these acquisitions, mergers and affiliations.

BACKGROUND AND SCOPE

As the ACLU notes in its May 21, 2013, letter to Governor Inslee, “26% of hospital beds were in religious hospitals in April 2010, today that figure is 40% and could rise to 45% by year’s end.” (See Appendix A) Our estimates, based upon the most current counts of available beds from the DOH, essentially concur with that assessment, with one caveat noted below pertaining to Swedish Health Services.

Per those data, we also found that all but one of the religious hospitals in Washington is affiliated with or owned by the Catholic Church; the sole exception is Walla Walla General which is owned by the Seventh Day Adventists Church. That church’s stance on reproductive rights, end-of-life care choices, and LGBT’s appear to generally concur with those of the Catholic Church.

Below is a brief summary of those acquisitions and affiliations:

- In 2010, the DOH data show 2960 available beds in religious affiliated or owned hospitals, and 8198 available beds in secular hospitals; based upon those counts the percent of available beds in religious affiliated or owned hospitals equaled 26.5%.
- In 2011, Southwest Washington Medical Center, with 333 available beds, and United General Hospital, with 25 beds, became affiliates of PeaceHealth; the percent of beds in religious hospitals increased to 29.7%.
- In 2012, Swedish Health Service became an affiliate of Providence Health Services. Swedish Health Service includes Swedish Medical Center at First Hill (699 available beds), Swedish Medical Center at Cherry Hill (254 beds), and Swedish Medical Center in Edmonds¹ (156 beds). Including these beds in the religious hospitals’ bed count increases that percentage to 39.4%. **However, it is important to note that the affiliation Swedish has with Providence differs from other hospitals’ affiliations – and, in fact, Swedish considers itself a secular institution.** While under the provisions of their affiliation they have agreed to not perform elective terminations, Swedish retains the right to perform an abortion if the mother’s life is at stake or if the fetus has a fatal anomaly; their physicians also retain the right to participate under the provisions of DWD when caring for terminally ill patients.²
- In 2013, Highline Community Hospital (189 beds) and Harrison Medical Center (255 beds) became part of the Franciscan Health System; Whitman Hospital and Medical Center (32 beds) became an affiliate of Providence Health Services; and, a new religious hospital opened, PeaceHealth Peace Island Medical Center (10 beds). Categorizing Swedish’ beds as religious, and notwithstanding any additional shifts before the end of this year, the percent of beds in religious hospitals would equal 44.0%; this corresponds to the percent highlighted in the ACLU letter. Categorizing Swedish’ beds as secular, the percent of beds in religious hospitals would equal 34.0%

¹ Swedish Medical Center in Edmonds remains a public district hospital, although it is leased by and under the management of Swedish Health Services. In August, 2013, Attorney General Bob Ferguson issued a legal opinion to the effect that public district hospitals that provide maternity services or information must also provide equivalent services or information about contraceptives and abortions.

² Ostrom, C. (2013, April 27). Hospitals’ proposed affiliation with Catholic systems opposed. Seattle Times. http://seattletimes.com/html/localnews/2020875885_catholichealthxml.html

While these increases in the proportion of religious hospital bed counts potentially portend limits in access to certain health care services, it is important to assess any actual current or past disparities between religious hospitals and secular ones, and – more importantly – between the communities served by each. Such an assessment provides a sense of the scope, magnitude and urgency needed in addressing the concerns raised. It does not, however, guarantee that practices yesterday and today will be similar to those tomorrow.

In this assessment, we have focused our data analysis on reproductive health care services and end-of-life care. For reproductive care, we looked at tubal ligations to assess community and regional as well as facility specific variations in inpatient rates. As a sub-analysis, we also assessed variations in rates for tubal ligations and an alternative and largely outpatient procedure, ESSURE implants, for the Medicaid population to determine the degree to which permanent sterilization procedures may have shifted from an inpatient to an outpatient setting in some communities. We also assessed county abortion rates to determine the degree to which any variations in those rates may be associated with religious hospitals' market penetration.

For end-of-life care, we had intended to assess access by analyzing the number of applications under the Death with Dignity Act in each county to determine if any variations were associated with the proportion of religious affiliated hospice providers serving those counties. However, we found that the Department of Health's Center for Health Statistics' (CHS) policy does not allow them to produce simple counts of applicants by county due to confidentiality concerns. CHS also determined that their data quality was too poor to produce non-identifiable age- and condition-adjusted rates. Our assessment, therefore, is somewhat cursory.

We also reviewed the rules and regulations as well as the processes and procedures used in filing and addressing patient and patient family complaints by hospitals and the Department of Health.

Finally, we have initiated an examination of recent purchases of physician clinics by religious or secular hospitals. Although not part of the initial concerns raised by the ACLU, we suspect that as health care reform moves forward and providers are incentivized to vertically integrate their patient care, the purchasing of physician offices by hospitals and hospital care systems will likely increase and potentially raise many of the same concerns. Our analysis of these data is on-going and will be developed more fully in a separate report.

Appendices have been provided on trends in hospital-specific tubal ligation rates and counts, and on county-specific abortions rates. The Appendices also include various background materials. Table 1, on the following page, lists the hospitals in Washington state by their religious or secular status.

Table 1
Hospitals by Religious or Secular Status - 2013

Religious (owned or affiliated)	Secular	
Harrison Memorial Hospital	Capital Medical Center	Newport Hospital
Highline Medical Center	Cascade Medical Center	North Valley Hospital
Lourdes Medical Center	Cascade Valley Hospital	Northwest Hospital
PeaceHealth Peace Island Medical Center	Central Washington Hospital	Ocean Beach Hospital
PeaceHealth Saint John Medical Center	Columbia Basin Hospital	Odessa Memorial Hospital
PeaceHealth Saint Joseph Hospital	Coulee Community Hospital	Olympic Medical Center
PeaceHealth Southwest Medical Center	Dayton General Hospital	Othello Community Hospital
Providence Centralia Hospital	Deaconess Hospital	Overlake Hospital Medical Center
Providence Holy Family Hospital	East Adams Rural Hospital	PMH Medical Center
Providence Mount Carmel Hospital	Evergreen Hospital Medical Center	Pullman Regional Hospital
Providence Regional Medical Center Everett	Ferry County Memorial Hospital	Quincy Valley Medical Center
Providence Sacred Heart Medical Center	Forks Community Hospital	Regional Hospital
Providence Saint Joseph's Hospital	Garfield County Memorial Hospital	Samaritan Hospital
Providence Saint Mary Medical Center	Grays Harbor Community Hospital	Seattle Cancer Care Alliance
Providence Saint Peter Hospital	Group Health Central Hospital	Seattle Childrens
Saint Anthony Hospital	Harborview Medical Center	Skagit Valley Hospital
Saint Clare Hospital	Island Hospital	Skyline Hospital
Saint Elizabeth Hospital	Jefferson Healthcare	Snoqualmie Valley Hospital
Saint Francis Hospital	Kadlec Regional Medical Center	Sunnyside Community Hospital
Saint Joseph Medical Center	Kennewick General Hospital	Tacoma General Allenmore Hospital
Saint Luke's Rehabilitation Institute	Kindred Hospital Seattle	Three Rivers Hospital
Swedish Medical Center - Cherry Hill*	Kittitas Valley Community Hospital	Toppenish Community Hospital
Swedish Medical Center - Edmonds*	Klickitat Valley Hospital	Tri-State Memorial Hospital
Swedish Medical Center - First Hill/Ballard*	Lake Chelan Community Hospital	University Of Washington Medical Center
Swedish Medical Center - Issaquah*	Legacy Salmon Creek Medical Center	Valley General Hospital
United General Hospital	Lincoln Hospital	Valley Hospital - Spokane
Walla Walla General Hospital	Mark Reed Hospital	Valley Medical Center
Whitman Hospital & Medical Center	Mary Bridge Children's Hospital & Health Center	Virginia Mason Medical Center
	Mason General Hospital	Wenatchee Valley Hospital
	Mid-Valley Hospital	Whidbey General Hospital
	Morton General Hospital	Willapa Harbor Hospital
	MultiCare Auburn Medical Center	Yakima Regional Medical and Cardiac Center
	MultiCare Good Samaritan Hospital	Yakima Valley Memorial Hospital

*Although affiliated, retains select secular autonomy

REPRODUCTIVE HEALTH CARE SERVICES

Tubal Ligations: Community Access

To assess current impacts on access to abortion and tubal ligation procedures, we began by identifying the religious hospitals' catchment areas for inpatient obstetrics (OB) services.

These catchment areas are defined as ZIP code areas where fifty percent or more of the inpatient OB admissions for women living in those ZIP code areas occurred in a religious hospital. Since women living in these catchment areas are more likely than others to receive their obstetrical care in a Catholic hospital, they are also more likely to be potentially affected by the health care directives established by the Catholic Church.

Figure 1 shows those catchment areas for 2010; Figure 2 shows those areas for 2013. In both Figures, the same inpatient data were used, 2009-2011 Washington, Oregon and border hospital Idaho records; only the hospitals' affiliations were changed for the two time periods.

Notable increases in the religious hospitals' catchment areas occurred in the more densely populated central and south Puget Sound region, including the Seattle environs and Kitsap county. This is largely due to categorizing Swedish as religious in 2012, which may be debatable. Changes also are evident in the urban and suburban Vancouver environs, as well as in Island, Mason and Whitman counties.

Using the 2011 catchment areas, we computed the percent of deliveries with tubal ligations within and outside the religious hospitals' OB catchment areas with inpatient discharges from 2009 to 2011 combined. In doing so, we looked at the percent of total deliveries that had had a tubal ligation and at the percent of C-sections that had had a tubal ligation. We assessed these separately because, as Figures 3a and 3b show, while nearly three-fourths (73%) of all inpatient births in Washington are vaginal deliveries, a full three-fourths (75%) of all inpatient tubal ligations are performed during a C-section delivery.

Figure 1
2010 Religious Hospitals' OB Catchment Areas
2009-2011 inpatient discharge data from WA, OR and ID

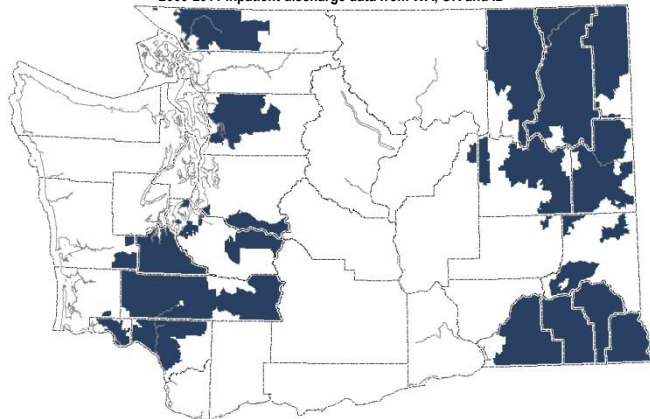


Figure 2
2013 Religious Hospitals' OB Catchment Areas
2009-2011 inpatient discharge data from WA, OR and ID

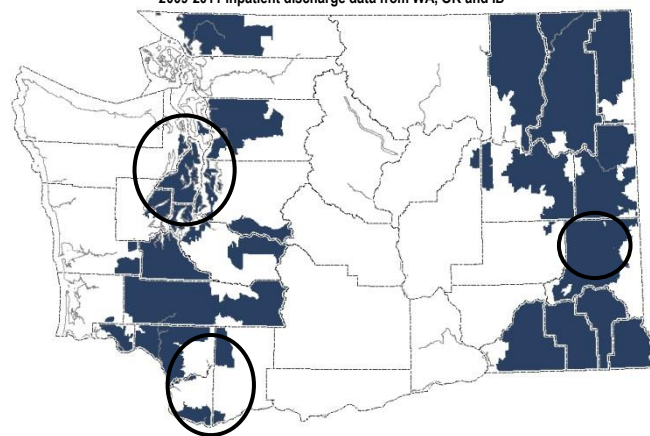


Figure 3a
Births by Delivery Type
2009-2011 inpatient discharge data from WA, OR and ID

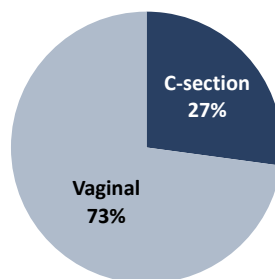
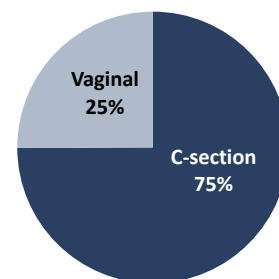
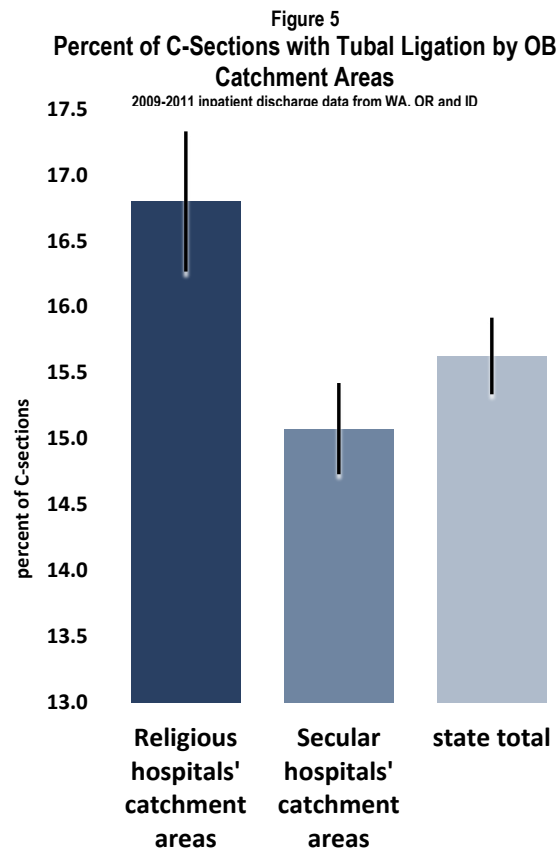
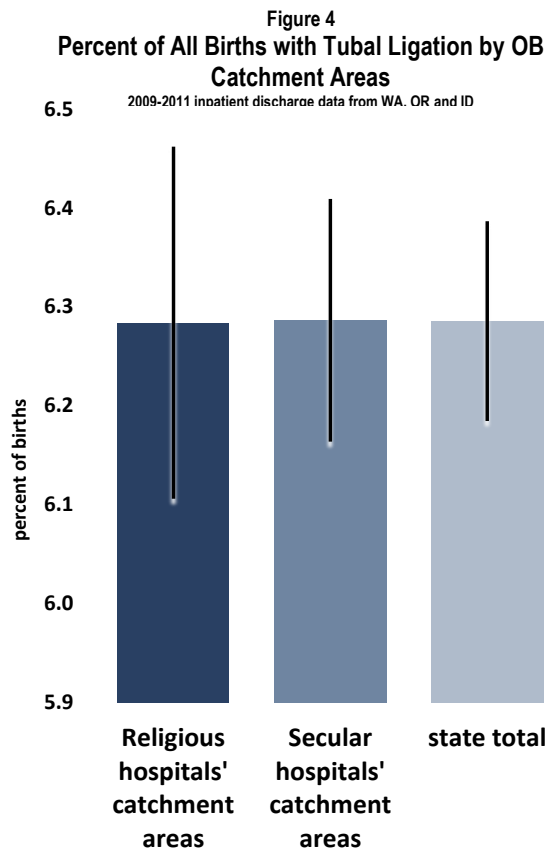


Figure 3b
Tubal Ligations by Delivery Type
2009-2011 inpatient discharge data from WA, OR and ID



The percent of tubal ligations in religious hospitals' OB catchment areas and those in secular hospitals' for all births and for C-sections only are shown in Figures 4 and 5.



Somewhat surprisingly, we see in Figure 4 that there is no difference between the percent of all inpatient births with tubal ligations in catchment areas served by religious hospitals and those served by secular ones.

Even more surprisingly, in Figure 5 we see that the percent of C-sections with tubal ligations is significantly higher among women living in religious hospitals' catchment areas than it is for those living in secular hospitals' areas. The percent in religious hospitals' catchment areas is also higher than the statewide percent.

For vaginal deliveries, religious hospitals do have a lower rate; however, the number of tubal ligations performed with vaginal deliveries is relatively small. See Table 2.

Table 2
Tubal Ligations by OB Catchment Area and Delivery Type

2009-2011 inpatient discharge data from WA, OR and ID

Vaginal deliveries

catchment area	vaginal deliveries	tubal ligations	% tubal ligations	95% CI
religious	53,432	956	1.8	± 0.11
secular	112,007	2,774	2.5	± 0.09
state tot	165,439	3,730	2.3	± 0.07

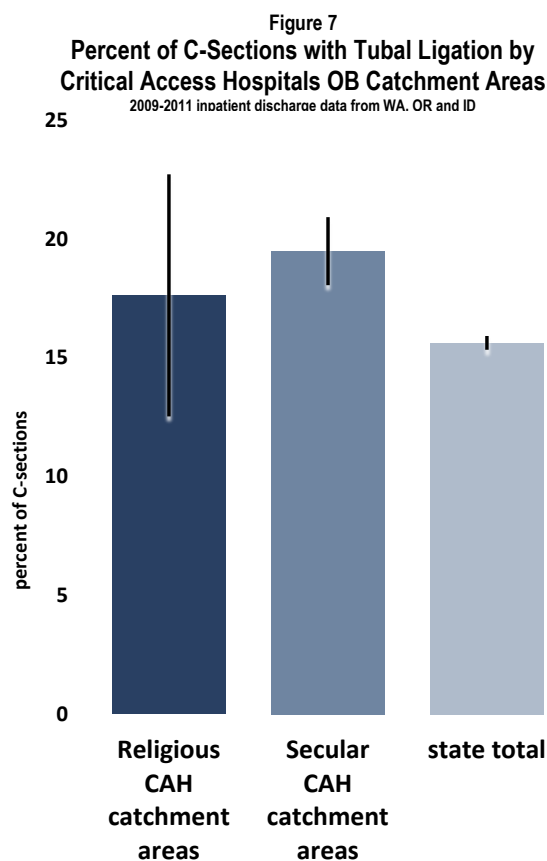
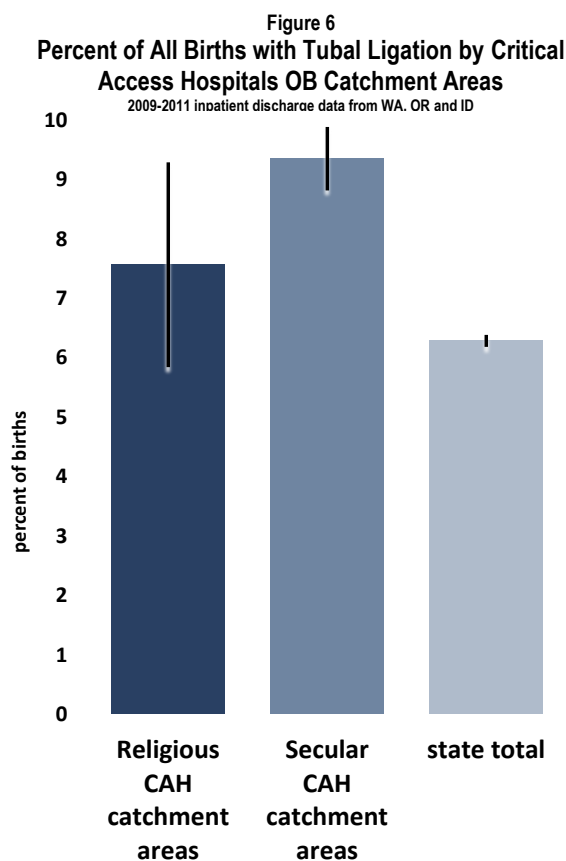
C-sections

catchment area	c-sections	tubal ligations	% tubal ligations	95% CI
religious	22,841	3,837	16.8	± 0.53
secular	48,544	7,319	15.1	± 0.35
state tot	71,385	11,156	15.6	± 0.29

All births

catchment area	all births	tubal ligations	% tubal ligations	95% CI
religious	76,273	4,793	6.3	± 0.18
secular	160,551	10,093	6.3	± 0.12
state tot	236,824	14,886	6.3	± 0.10

Critical Access Hospitals (CAH) play an important role in many rural communities. Women living in such communities often have limited choices in where they can have their births. Therefore, we also identified OB catchment areas for religious CAH's and secular CAH's and assessed the tubal ligation percentages in those areas (not shown). As Figures 6 and 7 show, here we have somewhat different results than we had seen earlier for all hospitals.



For all births, as seen in Figure 6, and for C-section deliveries, as seen in Figure 7, the differences between the tubal ligation percentages within religious and secular CAH catchment areas are not statistically significant, even though the percent appear higher in the secular communities. For all births and for C-sections there is also no significant difference between the religious CAH catchment percentages and the statewide percent. However, the tubal ligation percentages within the secular CAH catchment areas are significantly higher than the state percentage for all births and for C-sections.

Since this assessment of women living in religious hospital catchment areas or religious CAH catchment areas did not indicate that their percent of tubal ligations were lower than the secular or the state's percentages, we decided to see if any region in the state had higher or lower than expected inpatient tubal ligation rates. To do so, we used SaTScan³ to identify high and low risk areas, and ZIP codes as the unit of analysis. For the first iteration of this model all inpatient births were used as the denominator

³ SaTScanTM is a trademark of Martin Kulldorff. The SaTScanTM software was developed under the joint auspices of (i) Martin Kulldorff, (ii) the National Cancer Institute, and (iii) Farzad Mostashari of the New York City Department of Health and Mental Hygiene.

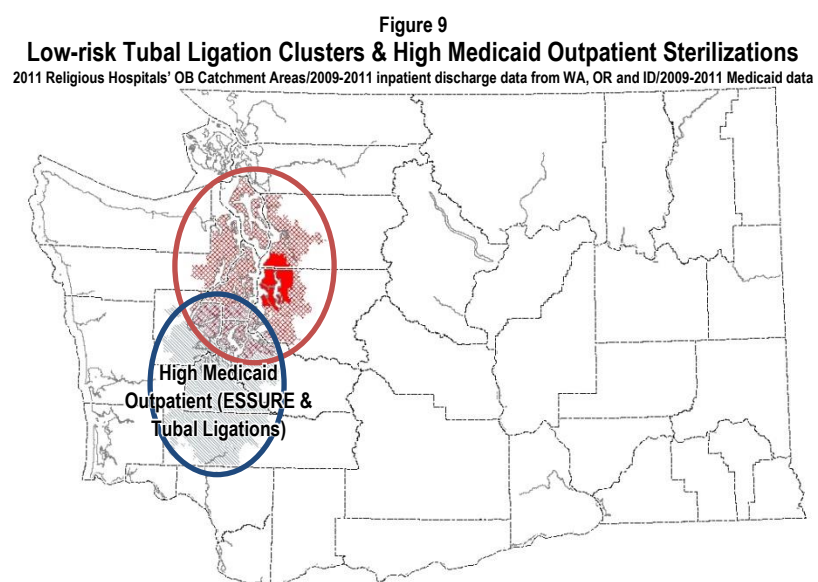
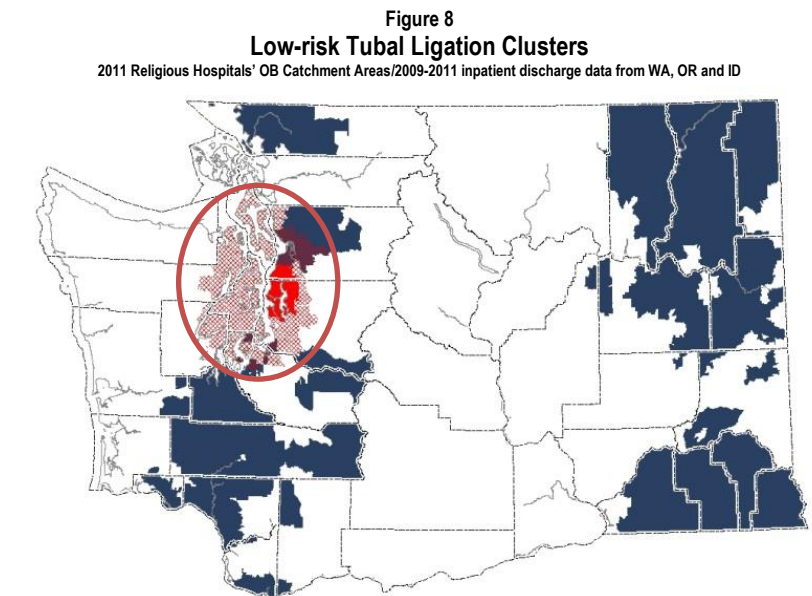
and those births with a tubal ligation were used as the numerator; for the second iteration, all C-section deliveries were used as the denominator and those C-sections with a tubal ligations were used as the numerator.

Figure 8 shows the 2011 religious hospital catchment areas, and two clusters: one large area within the south and central Puget Sound region that was identified as having significantly lower than expected rates of inpatient tubal ligations for all births, and a second smaller clusters that fell within that same region and was identified as having significantly lower than expected tubal ligations among C-section-only deliveries.

By and large, neither of these regions was within a religious hospital catchment area for the 2009-2011 time periods. But they are within Seattle and the Seattle-Metro region, and it is possible that women living in these areas may have more readily available options for birth control, including access to procedures performed in an outpatient setting. Unfortunately, data on the general population's health care utilization are limited to inpatient care. But Medicaid data are available for both inpatient and outpatient care services, and although Medicaid clients are not necessarily representative of the general population, they do account for about half of our state's births.

Using Medicaid data we found there were 3014 tubal ligations or *ESSURE* implants between 2009 and 2011. *ESSURE* is an emerging alternative to a tubal ligation and can be implanted in a physician's office. However, of the 3014 procedures identified, only 74 were performed in an outpatient setting.

From those limited data, we nonetheless found two areas with significantly higher than expected outpatient cases, one in the northeast (not shown) and one which partially overlaps the south Puget Sound portion of the low tubal ligation cluster. See Figure 9.

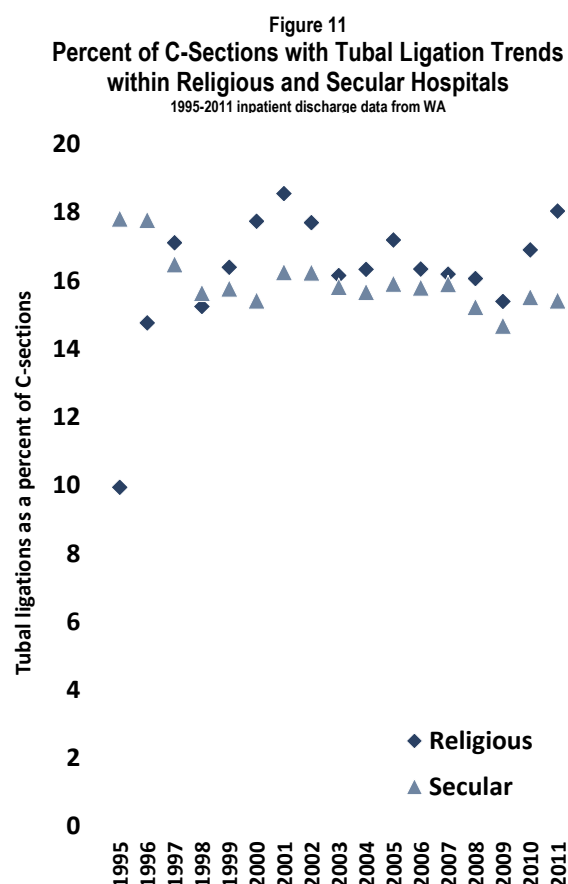
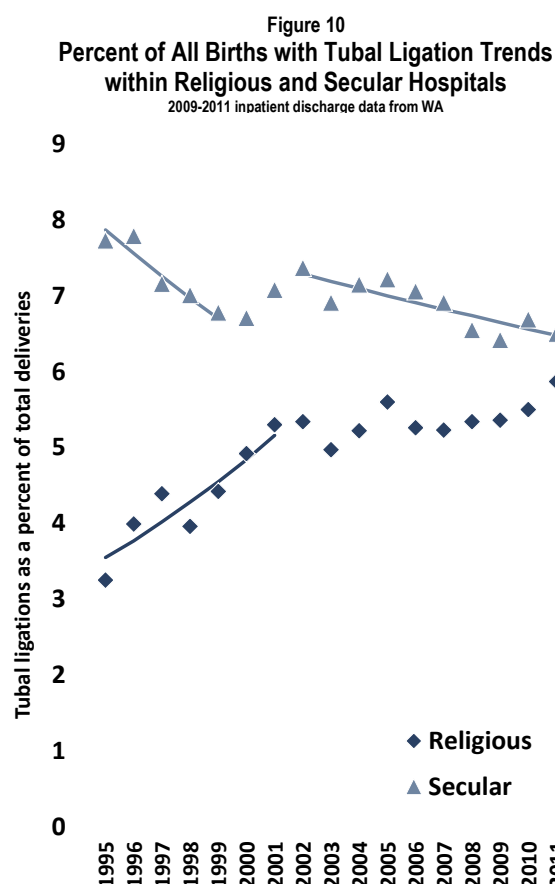


The number of cases in both these clusters was small (in the larger south Puget Sound region, the actual was 29 and the expected was 8.7), so caution is warranted in interpreting the results.

Keeping that caution in mind, our findings suggest that the low inpatient tubal ligation cluster initially shown in Figure 8, does not appear to be of function of physicians or patients choosing an outpatient tubal ligation or ESSURE procedure over an inpatient one. Instead, it appears as though inpatient tubal ligation rates are low in that region for some other reason or reasons.

Tubal Ligations: Hospital Profiles

As seen in the previous section, communities within or outside religious hospitals catchment areas do not necessarily differ in their rates of inpatient tubal ligations – and when they do differ, they do not necessarily do so in an expected manner; that is, communities within religious hospital catchment areas sometimes have higher rates of tubal ligations than those outside those catchment areas. To better understand why this occurs, we examined the rates and trends among religious and secular hospitals.



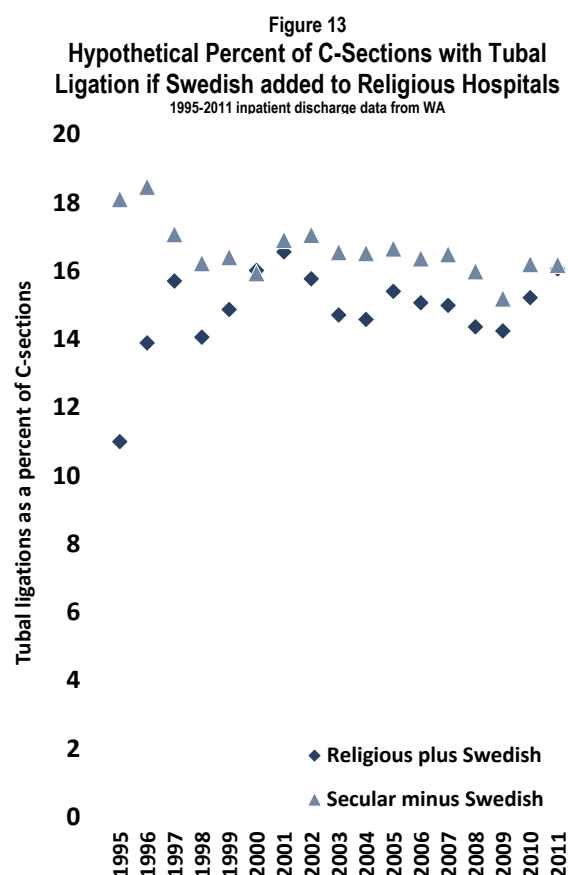
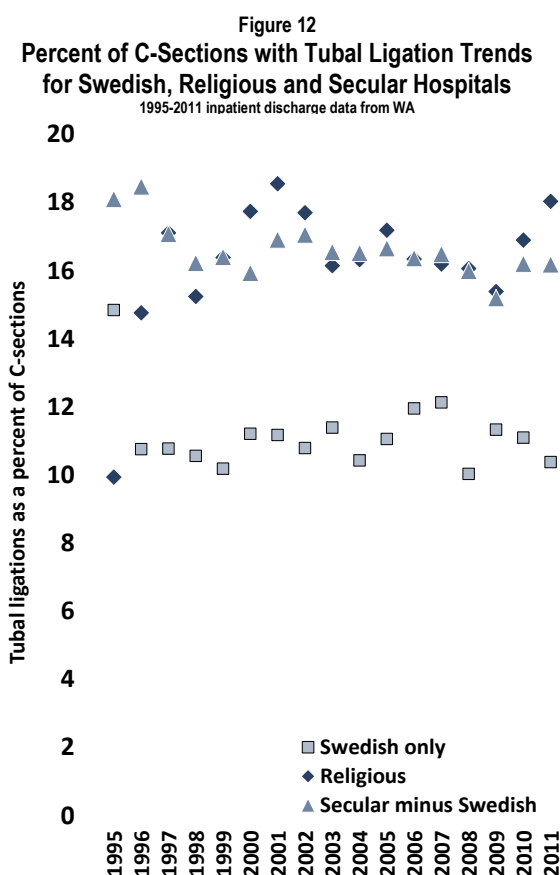
In Figure 10 we see that for secular hospitals there have been two significant downward trends in the percent of all births with tubal ligation, one from 1995 to 1999 and the other from 2002 to 2011. For religious hospitals, there had been upward trend from 1995 to 2001, but no subsequent trend from that point forward. The net effect is that by 2011 the difference between secular (6.5% \pm 0.2) and religious (5.9% \pm 0.3) hospitals' tubal ligation rates for all births has appreciably narrowed, although the difference remains statistically significant.

In Figure 11 we see that there is no trend in the percent of C-section deliveries with tubal ligations for either the secular or religious hospitals. Surprisingly, too, we see that since 1997 the percent of C-sections with tubal ligations within religious and secular hospitals have generally not been significantly different from one another, although in 2011 the percent of C-sections with tubal ligations in religious hospitals (18.0% \pm 1.0) is significantly higher than the percent in secular hospitals (15.4% \pm 0.6).

This finding of proportionately higher C-sections with tubal ligations in religious rather than secular hospitals is consistent with our findings in assessing communities' rates.

It may be worth noting, however, that these differences between secular and religious hospital would be affected depending upon how Swedish hospitals are categorized for 2012 and beyond, and caution should be exercised in assessing future trends.

As Figure 12 shows, the percent of C-sections with tubal ligations has been consistently lower at Swedish than in either the secular or religious hospitals as a whole. By excluding Swedish, we also see the differences between the percent of tubal ligations in religious and secular hospitals lessen, although the percent in religious hospitals generally remains higher.



However, as Figure 13 shows, if we add Swedish to the religious hospitals and subtract it from the secular ones, the percent of tubal ligations in secular hospitals becomes consistently higher than the percent in religious ones.

Since Swedish' 2012 affiliation with Providence differs from other hospitals' affiliations, depending upon how they are categorized, data from that point forward could show a marked decline in the percent of

tubal ligations in religious hospitals; this decline would, in part, be a function of the consistently low rates seen at Swedish.

Appendices B1 and B2 show hospital-specific trends in the number of tubal ligations performed per year as well as their percent per delivery.

Abortions

In Figure 14 we see the 2011 religious hospitals' OB catchment areas and the four counties whose abortion rates are significantly higher than the state's rate: Snohomish, King, Pierce and Thurston.

In Figure 15, counties whose abortion rates are significantly lower than the state's rate are shown. These include nearly all the counties in eastern and southwest Washington.

Included in both maps are the family planning clinics that either directly provide or refer clients for abortion services.

There appears to be little concordance between these counties high or low abortion rates and the religious hospitals' OB catchment areas. Thurston county, for instance, has a higher abortion rate than the state, but it is also part of a region where half or more of the inpatient OB services are provided in religious hospitals.

Conversely, nearly all of the central Washington counties, from Okanogan to Klickitat, have lower abortion rates than the state, but most inpatient OB services in those counties are provided through secular hospitals.

This lack of concordance between religious hospitals' OB catchment areas and county abortion rates is not surprising: In 2011, only 1.1% of the abortions statewide were performed while the woman was in a hospital as inpatient; similar proportions are also seen in previous years.

Although not readily quantifiable, there does appear to be somewhat more of a relationship between family planning service availability and abortion rates. In low abortion rate Lincoln, Stevens and Pend

Figure 14
**HIGH Abortion Rate Counties with
Religious Hospitals' OB Catchment Areas**
2009-2011 DOH Abortion Data

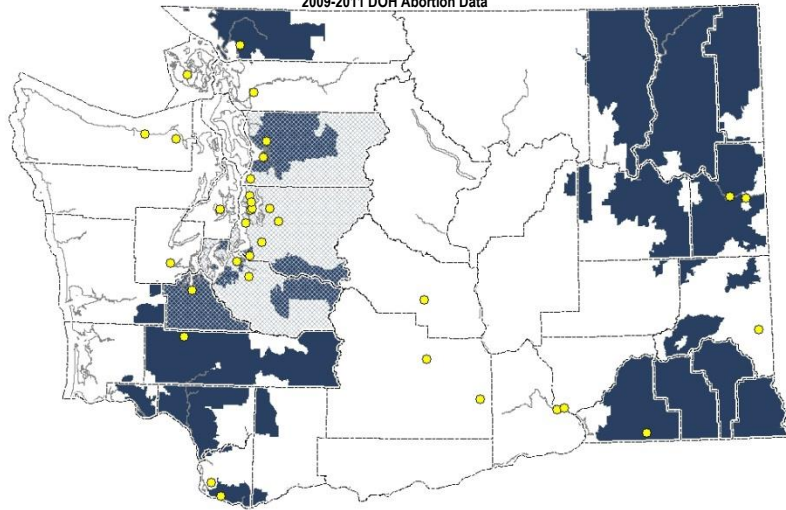
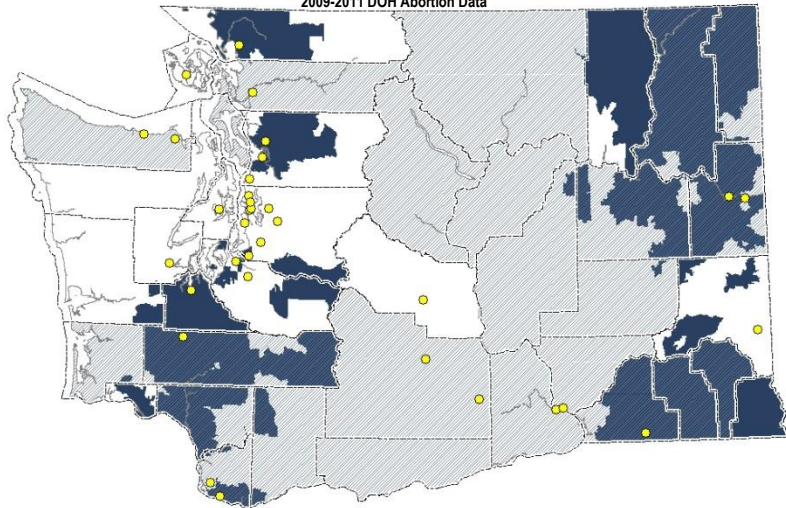


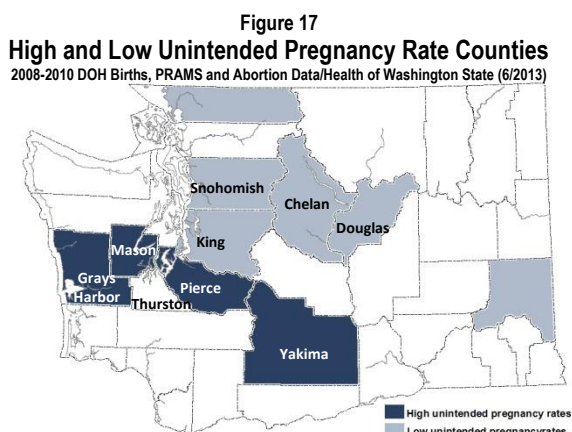
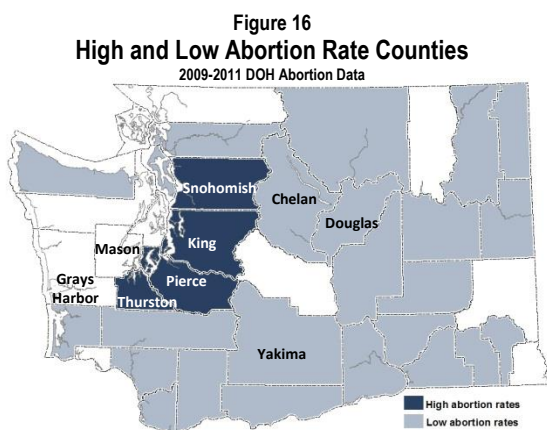
Figure 15
**LOW Abortion Rate Counties with
Religious Hospitals' OB Catchment Areas**
2009-2011 DOH Abortion Data



Oreille counties, for instance, seventy-five percent or more of those counties' residents seeking an abortion had to travel to Spokane for that service; so, too, do more than sixty percent of the women in equally low abortion rate Okanogan county. Similarly, for Chelan county residents, forty-seven percent go to King for services and forty-one percent go to Yakima; for Douglas residents, thirty-five percent go to King and fifty-one percent go to Yakima.

But such a pattern only goes so far: In low abortion rate Yakima county, for instance, nearly ninety percent of those residents receive their abortion care within their county. Appendix C shows these county flow percentages. Appendix C also includes county-specific trends of abortion rates.

Figure 16 combines the abortion rate data shown in Figures 14 and 15, but excludes the religious hospital catchment areas. Figure 17 shows counties with significantly high or low unintended pregnancy rates. These rates were developed by DOH and were derived from 2008-2010 birth and abortion statistics as well as survey data from the Pregnancy Risk Assessment Monitoring System (PRAMS).



In comparing the two maps, we see that both the unintended pregnancy rate and the abortion rate are high in Pierce county, and that both are low in Chelan and Douglas counties; this seems consistent with the notion that areas with high unintended pregnancy rates would have high abortion rates, and conversely, areas with low unintended pregnancy rates would have low abortion rates.

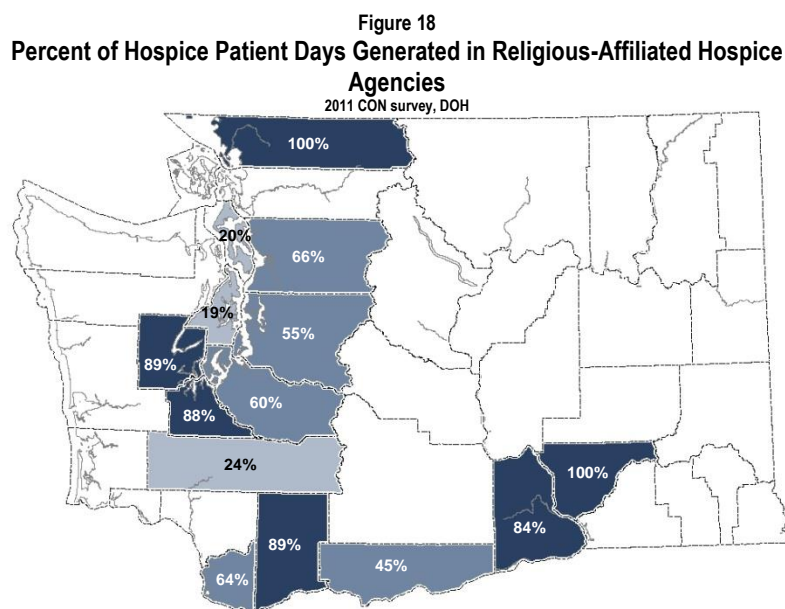
In Yakima, however, we see a high unintended pregnancy rate and a low abortion rate. And in King and Snohomish counties we see low unintended pregnancy rates and high abortion rates. These findings suggest a higher degree of complexity and the likelihood that multiple factors may play a role in choosing to have an abortion and in addressing an unintended pregnancy.

END-OF-LIFE CHOICES

Our ability to assess equitable access to end of life choices, as prescribed within the Death with Dignity Act (DWD), was constrained by data policy and data quality issues. Due to confidentiality concerns, the DOH Center for Health Statistics (CHS) does not develop or release county-specific counts, percentages or crude rates of DWD applicants; such data, they maintain, may be potentially identifiable.

In addition, when CHS was asked to provide county-specific rates adjusted for under/over age 65 and for cancerous versus non-cancerous conditions, making those rates comparable among counties and, concurrently, non-identifiable, CHS noted that in doing so they had determined that the DWD data quality was too poor to meet DOH standards for publication. Their data collection purposes are instead designed to collect documentation to monitor compliance, and to use the information contained within those documents to produce an annual statewide summary report, but not to maintain an analytical database. The executive summary of their 2012 annual report is in Appendix D.

The DOH Certificate of Need (CON) program was able to provide us with patient day counts by county for each hospice agency in the state. CON annually surveys hospice agencies to acquire these patient day data, and uses them in developing forecasts for future need using a weighted rate similar to the one requested from CHS for DWD applicants. All hospice agencies must receive CON approval to provide services within a county.



From the CON list of hospice agencies, we performed an internet search to identify those that had a religious affiliation. Then, using the CON survey data, we calculated the percent of hospice patient days provided within a county by religious hospice agencies. Figure 17 shows those percentages; counties not highlighted are served by secular hospice agencies only.

According to the CHS annual DWD report, nearly ninety percent of the DWD applicants come from counties in western Washington. As seen above, that is the same general area where most religious hospice agencies are located.

It is unfortunate, but to some degree understandable, that access to DWD data is so constrained. Given the little information we do have, it does not appear as though the western half of Washington, which is largely served by religious hospice agencies, has utilized the DWD end-of-life choice less than those on the east side.

“Would more terminally ill patients take advantage of this end-of-life choice if hospice providers in western Washington were not affiliated with a religious organization?” is a question we cannot answer. Anecdotal information does suggest such a possibility, especially if the patients or their family members are not aware of their options under DWD.⁴ And it is important to note that the policies of the Providence, Franciscan and PeaceHealth health care systems explicitly preclude them from assisting and/or cooperating in any way in a patient’s decision to participate in DWD, although they do continue to provide hospice care to patients who have enrolled in DWD. See Appendix E.

Outside of religious considerations, there are financial barriers for patients seeking end-of-life choices under DWD. Specifically, Medicare will not reimburse for “items and services administered to a beneficiary for the purpose of causing or assisting in causing death (assisted suicide).”⁵ This would include the two separate physician office visits that are required under DWD; such visits, therefore, must be paid out-of-pocket or through a secondary insurer in order to comply with the law.

⁴ “Bellingham widow persuades hospice to inform patients of Death with Dignity law” Compassion and Choices website accessed November 15, 2013 <http://www.compassionandchoices.org/2010/10/11/bellingham-widow-persuades-hospice-to-inform-patients-of-death-wih-dignity-law/>

⁵ “Items and services that are not covered under the Medicare program” Centers for Medicare and Medicaid Services website accessed November 15, 2013 [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Items_and_Services_Not_Covered_Under_Medicare_Booklet\(CN906765\).pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Items_and_Services_Not_Covered_Under_Medicare_Booklet(CN906765).pdf)

DISCRIMINATION

DOH Health Service Quality Assurance Division (HSQA) was contacted regarding the rules and regulations as well as the processes and procedures used in filing and addressing patient and patient family complaints for perceived and/or actual discriminatory practices based upon sexual orientation.

They noted that there are three broad options available in filing a complaint: First, HSQA maintains a complaint intake phone number and website; second, hospital accrediting organizations, such as the Joint Commission and the Center for Improvement of Healthcare Quality, also maintain complaint hot-lines and websites; and, third, hospitals themselves are required to have a grievance process in order to address patient and/or visitor complaints.

In addition, the Centers for Medicare and Medicaid Services (CMS) revised federal regulations in 2011 that apply to Acute Care Hospitals and Critical Access Hospitals requiring them to have policies and procedures in place to protect a patient's right to delegate decisions to representatives including same sex partners; Appendix F includes the Survey & Certification letter outlining that policy.

HSQA also reported that it was unaware of any instance in the past five years of a complaint being lodged against a hospital that pertained to discrimination against a same sex partner.

RECAP AND CONCLUSIONS

It is clear that there is a growing trend in hospitals being purchased by or becoming affiliated with religious healthcare organizations. Concerns about access to certain health care services are therefore understandable.

However, within a select set of reproductive health care services the data do not show that communities served by religious hospitals have apparent access to care barriers. On the contrary, we found that for at least one service, tubal ligations following a C-section, those communities where half or more of the residents' obstetrical inpatient stays occurred in a religious hospital actually had rates that were higher than those communities served mostly by secular hospitals.

Similarly, for rural communities generally dependent on Critical Access Hospitals (CAH) for inpatient obstetrical care, we found that there was no statistically significant difference between the rates in those rural communities serviced by religious CAHs and those served by secular ones; however, we did find that the tubal ligation rates in communities served by secular CAH hospitals were significantly higher than the statewide rate.

In our empirical identification of any region in the state with lower than expected tubal ligation rates, we found that it was the mostly urban central Puget Sound region – where obstetrical care is more apt to occur in a secular hospital – that had the lowest rates.

Among the hospitals themselves, we did see that the overall tubal ligation rates in secular hospitals are generally higher than those in religious ones; however, the differences between the two have been narrowing, with the rates trending downward in secular hospitals while remaining essentially flat in the religious ones. We also noted that most tubal ligation occur with a C-section delivery, and while no trend was identified for either secular or religious hospitals' tubal ligation rates with C-sections, we did see that those rates within religious hospitals were generally higher than those within secular hospitals, although the differences were not statistically significant.

We also found that one hospital system – Swedish – generally had appreciably lower tubal ligation rates than other larger medical centers. We noted, too, that the Swedish 2012 affiliation agreement with Providence makes it unclear if they should be categorized as secular or religious. And, depending upon how they are categorized, the statewide trends in secular and religious hospitals' tubal ligation rates will be affected.

In assessing county-specific abortion rates, we did not detect any readily apparent differences that corresponded to the religious affiliations of the hospitals serving each county. This finding, however, was not surprising; less than 1% of the abortions performed statewide are performed in a hospital inpatient setting. We also found little correlation between counties' unintended pregnancy rates and their abortion rates. Taken in sum, these findings suggest a high degree of complexity and the likelihood that additional factors play a role in determining abortion and unintended pregnancy rates.

For end-of-life choices, we found there was insufficient data to perform anything more than a cursory assessment. Per that limited assessment, we did not observe any findings that would suggest counties served by religious hospice agencies had lower rates of Death with Dignity (DWD) applicants than those served by secular ones. However, we did find that many counties are served exclusively or nearly exclusively by religious hospice agencies, and that it is the explicit policy of those agencies to not

participate in any way with a patient's decision to exercise their choice under DWD. We also noted financial barriers in accessing DWD care.

In assessing discrimination by hospitals due to the sexual orientation of the patients, there does appear to be mechanisms for reporting any such practices, as well as policies prohibiting such practices. We also heard that no such complaints had been filed with DOH for at least the last five years.

Finally, we have initiated an examination of changes in ownership of physician offices and freestanding clinics; once the necessary data are acquired, we believe this will allow us to further ascertain the potential impact on communities served by clinics that have recently been purchased by religious health care organizations. We also believe that additional data sets, such as an all-payer database, are needed to more fully ascertain the impacts of these acquisitions, mergers and affiliations.

Nonetheless, taken in total, our findings do not suggest that access to reproductive health care services that fall outside the directives of the U.S. Conference of Catholic Bishops is limited in communities served by religious hospitals. Nor do we see differential access to Death with Dignity choices in communities served by religious hospice agencies, although our access to pertinent data was limited.

We also did not find any instances of discrimination associated with a patients' or their families' sexual orientation.

But, as noted earlier, since current practices do not guarantee future practices, we suggest that access to care – as well as changes in facility and clinic ownership – should be monitored.

Appendices



May 21, 2013

Governor Jay Inslee
Office of the Governor
P.O. Box 40002
Olympia, WA 98504-0002

**Re: Request for a Six-Month Moratorium on Agency Decisions
Related to Pending Hospital Transactions**

Dear Governor Inslee,

ACLU OF WASHINGTON
901 FIFTH AVENUE
SUITE 630
SEATTLE, WA 98164
T/206.424.2184
WWW.ACLU-WA.ORG

JEAN ROBINSON
BOARD PRESIDENT

KATHLEEN TAYLOR
EXECUTIVE DIRECTOR

The undersigned organizations urge your immediate action to protect Washingtonians' access to health care. Patients are at risk of being denied medically appropriate health care due to the unprecedented number of medical facilities in Washington that are considering or planning mergers with religious health care corporations. When such mergers take place, secular hospitals are required to follow religious doctrine, resulting in patient care dictated by someone else's religious beliefs, not the patient's needs or interests.

Serious state constitutional concerns arise when public, tax-funded hospitals consolidate with religious health care corporations. The Washington Constitution explicitly prohibits tax dollars and public property from being used to support religious establishments. Yet some of these completed and pending transactions involve public hospitals ceding operations to religious health care corporations, and include long-term taxpayer subsidies.

As leader of our state, we ask you to act immediately to safeguard patients' access to all lawful and medically appropriate health care services by: (i) enacting a six-month moratorium on any decision by the Washington State Department of Health on proposed or pending applications related to hospital ownership, operation, or management; and (ii) utilizing this six-month period to conduct a community health needs assessment that would provide an objective evaluation of such mergers' impact on patients' ability to access medically appropriate health care services and provide policy guidance moving forward.

Religious Hospital Mergers are a Serious and Growing Problem in Washington

National expert group MergerWatch reports that the number of pending, simultaneous religious hospital mergers in Washington is unprecedented in the 15 years it has tracked the issue. While 26% of hospital beds were in religious hospitals in April 2010, today that figure is 40% and could rise to 45% by year's end. Already, in certain parts of the state, the only option available to residents is religious-based

health care. Several well-publicized incidents highlight the problems that arise when religion interferes with medical judgment and patient care.¹

The hospital transactions underway in Washington are primarily with Catholic institutions,² which are required to abide by the Ethical and Religious Directives for Catholic Health Care Services (“the Directives”) promulgated by the U.S. Conference of Catholic Bishops.³ The Directives restrict access to the full range of reproductive health care services for men and women, severely limit a patient’s ability to make end-of-life health care choices that will be respected, and raise the likelihood that LGBT families will be unable to access health care services consistent with their medical needs, free from discrimination based on religious teachings.

No health care facility serving Washington’s public should be allowed to refuse patients these kinds of medically appropriate services based on religious doctrine.

Washington is a National Leader in Patient Protection and Non-Discrimination

Washington voters have consistently led the nation in championing bodily autonomy, health care choice, and LGBTQ rights. The Reproductive Privacy Act, enacted via initiative in 1991, establishes as that “every individual has the fundamental right to choose or refuse birth control,” and “every woman has the fundamental right to choose or refuse to have an abortion.” In 2008, voters enacted the Death with Dignity Act, which respects the end-of-life choices of terminally ill adults, including the decision to end their lives. And in 2006, the legislature passed the landmark Anderson Murray Anti-Discrimination Law, which prohibits discrimination based on sexual orientation or gender expression and identity, including by providers of medical services.

The current volume and pace of religious hospital mergers would allow the Directives to interfere with patients’ ability to exercise their rights under all three of these landmark laws.

Washington’s Leaders Must Act Now to Preserve Patient Rights

By enacting the moratorium requested above and halting state action on mergers for the next six months, you will give our state’s leaders an important opportunity to gather data and consider in-depth how these fast-moving transactions are changing the face of health care access in Washington.

In addition, the assessment of community health care needs requested above will help ensure that all Washingtonians can access affordable health care, regardless of where

¹ See Attachment A for articles: Rob Stein, *Religious Hospitals’ Restrictions Sparking Conflicts*, *Scrutiny*, WASH. POST., Jan. 19, 2011; Jonathan Cohn, *Unholy Alliance*, *THE NEW REPUBLIC*, Feb. 22, 2012; Jon Perr, *Expanding Catholic Hospitals Put Reproductive Care, Women’s Health at Risk*, *DAILY KOS*, Mar. 8, 2012.

² Four out of the five religious health care corporations that operate in Washington are affiliated with the Catholic Church: Ascension Health, Franciscan Health System (a subsidiary of Catholic Health Initiatives), PeaceHealth, and Providence Health & Services.

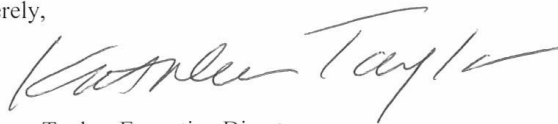
³ See Attachment B for a sampling of the restrictions on health care services imposed by the Directives.

they live. We urge your office use these six months to move forward with the important community health needs assessment called for in RCW 43.370. That law called for an initial report by 2010, but it was never completed. Such an assessment would evaluate the statewide impact of recently completed and pending transactions on patients' ability to access medically appropriate health care services consistent with state law.

Hospital mergers are often intended to improve coordination of patient care and increase system efficiencies. But where mergers involve religious health care corporations, safeguards are needed to ensure health care decisions are based solely on medically accepted standards of care and the law, not religious directives. Together, the moratorium and assessment requested above would provide an opportunity for our leaders to consider what safeguards are needed in this context.

Thank you for your leadership in taking these immediate steps to protect Washington's patients.

Sincerely,



Kathleen Taylor, Executive Director
ACLU of Washington

Deborah Oyer, MD, Medical Director
Aurora Medical Services

Robb Miller, Executive Director
Compassion & Choices, Washington

Lisa Stone, Executive Director
Legal Voice

Linda McCarthy, Executive Director
Mt. Baker Planned Parenthood

Rachel Berkson, Executive Director
NARAL Pro-Choice Washington

Janet Varon, Executive Director
Northwest Health Law Advocates

Mary Kay Barbieri, Chair
People for Healthcare Freedom

Elaine Rose, CEO
Planned Parenthood Votes Northwest

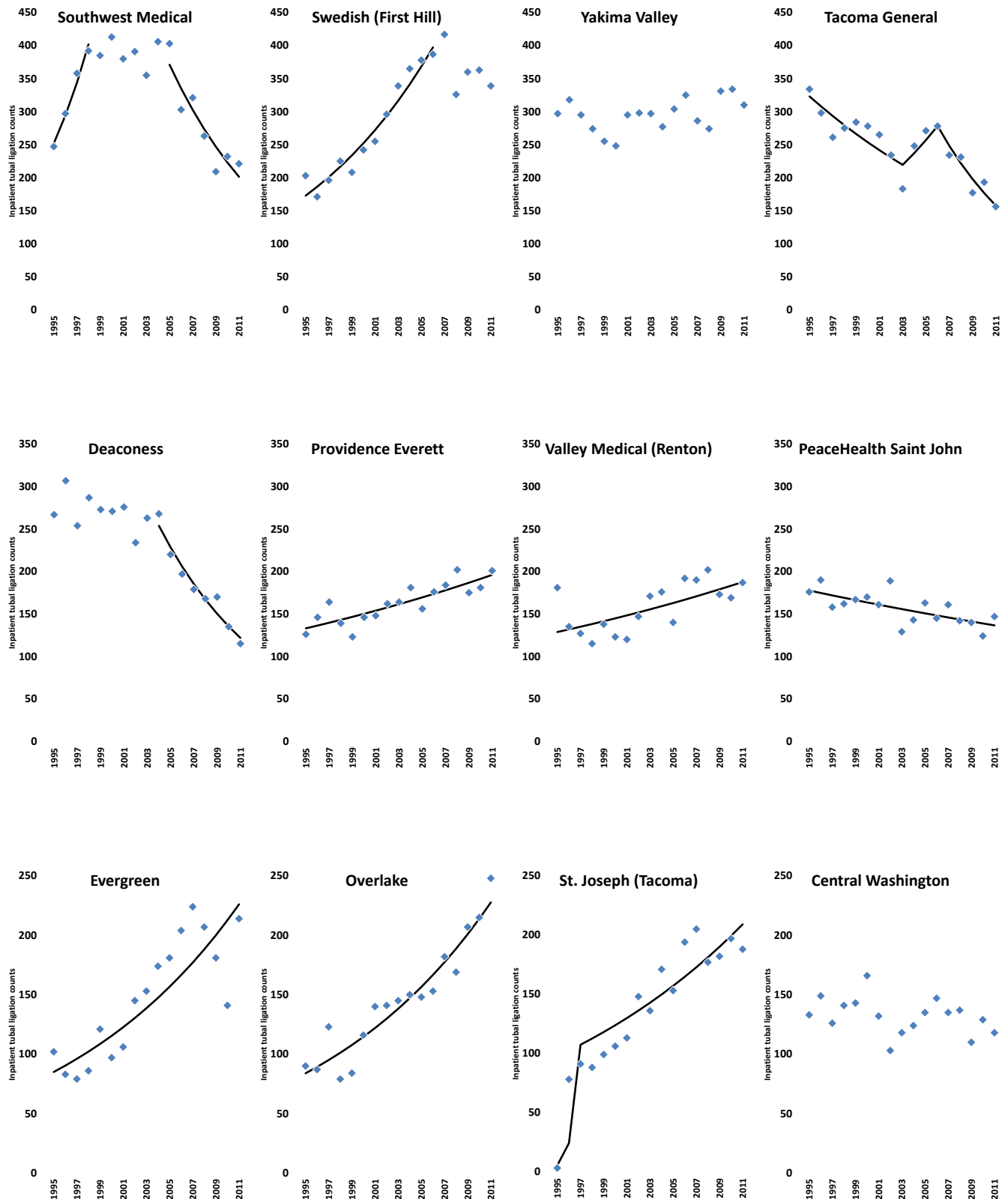
Mike Travis and Karen Gold, Co-
Presidents
PFLAG Washington State Council

Monica Harrington, Co-Chair
Washington Women for Choice

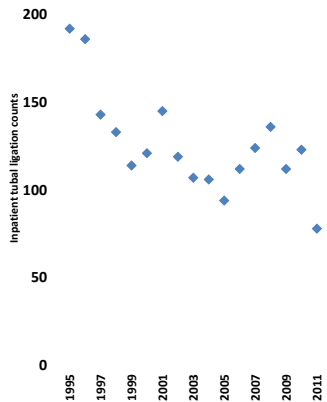
Enclosures

Appendix B1

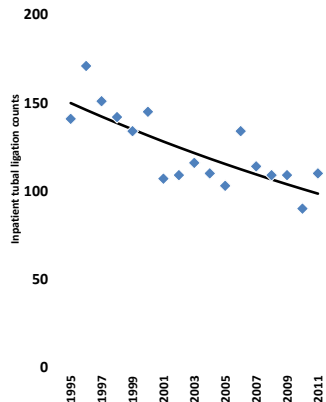
Trends in tubal ligations for the 24 highest volume hospitals, 1995-2011 (CHARS, DOH)



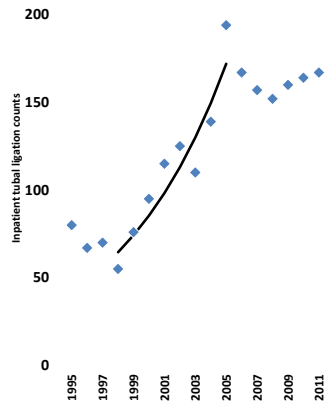
Harrison Memorial



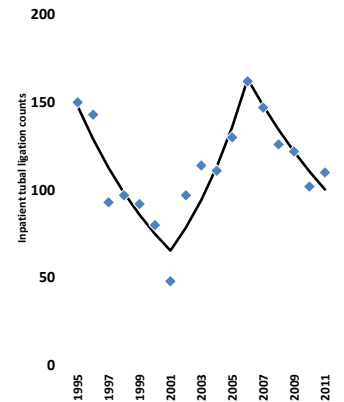
Samaritan



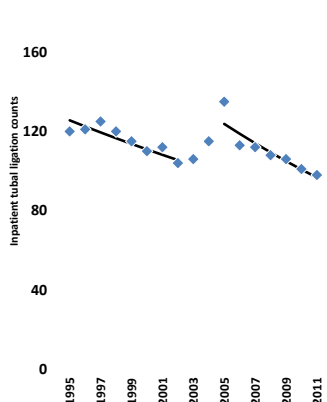
Kadlec Medical Center



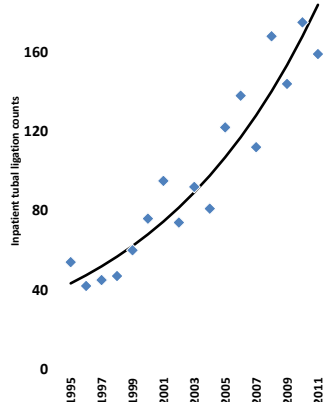
Kennewick General



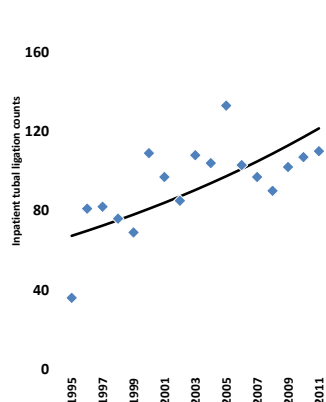
University of Washington



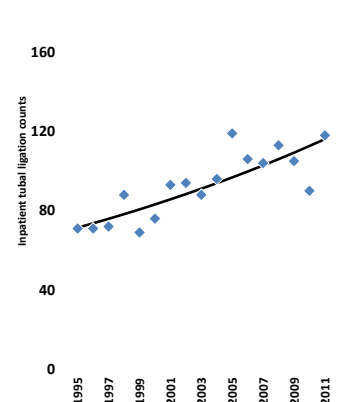
Sacred Heart



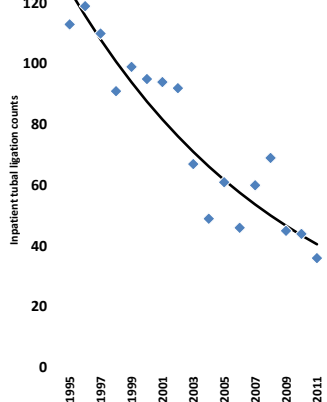
PeaceHealth St. Joseph



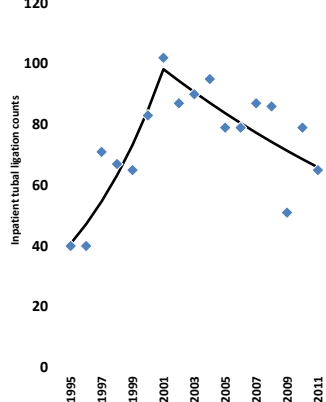
Providence St. Peter



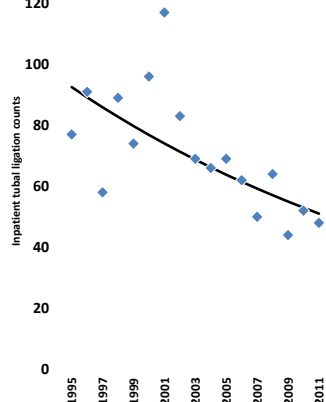
Swedish (Edmonds)



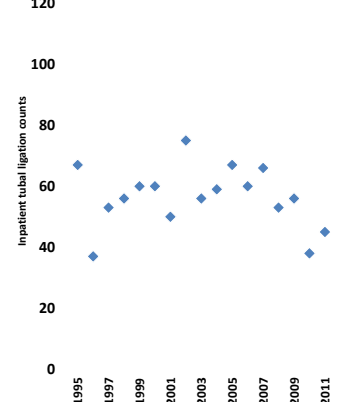
Capital Medical



Highline Community

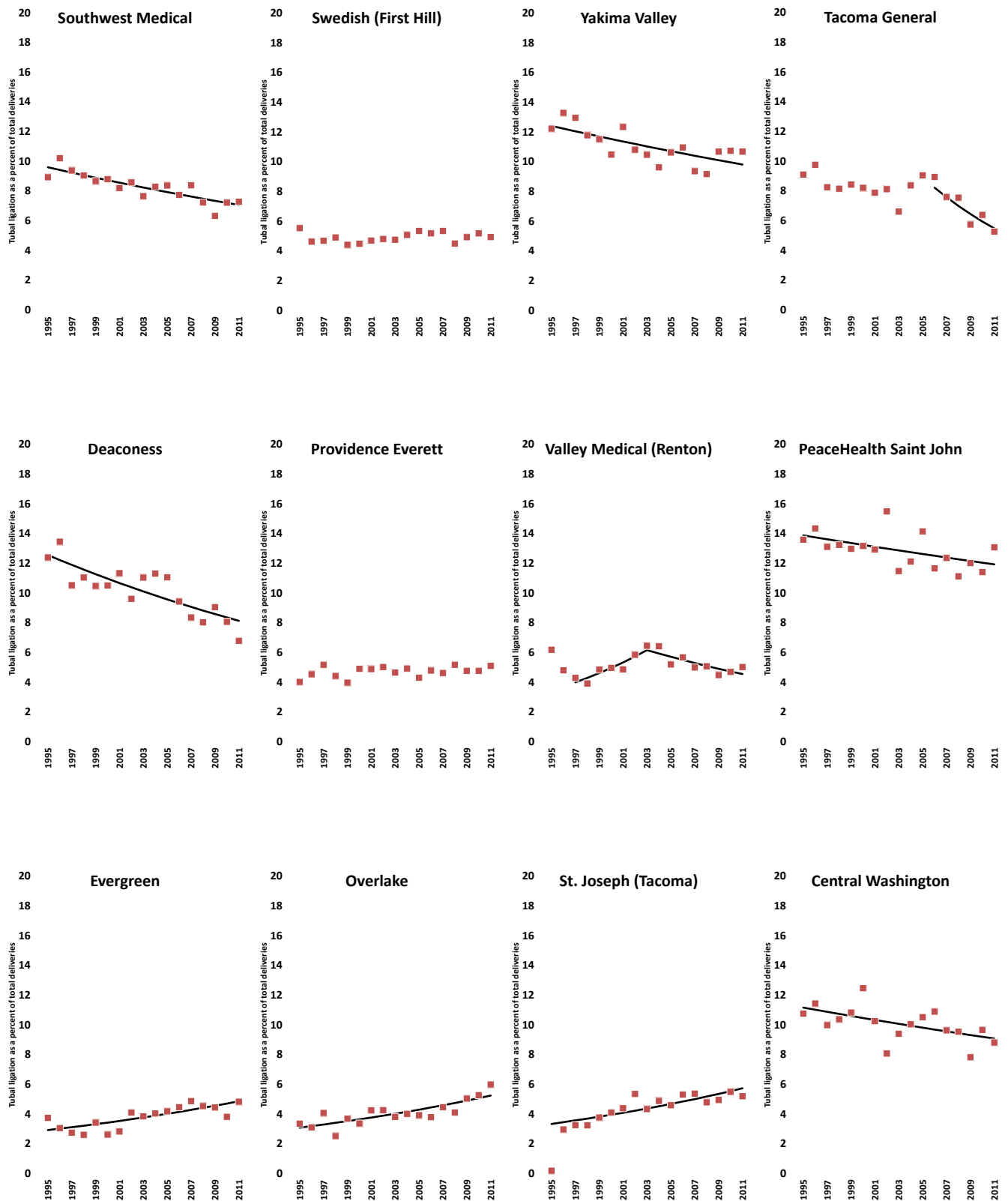


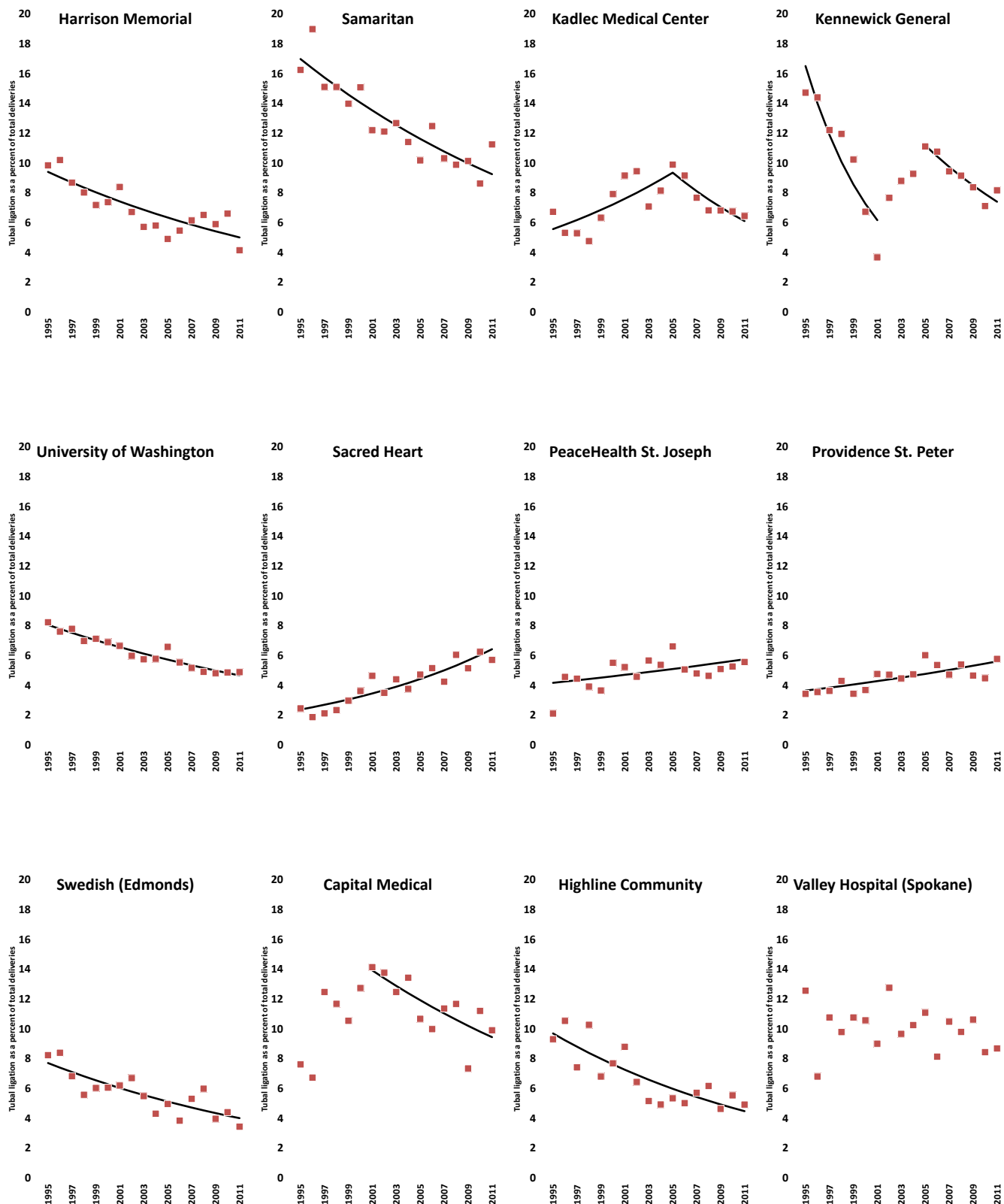
Valley Hospital (Spokane)



Appendix B2

Trends in tubal ligations as a percent of hospitals' total deliveries for the 24 highest volume hospitals, 1995-2011
(CHARS, DOH)

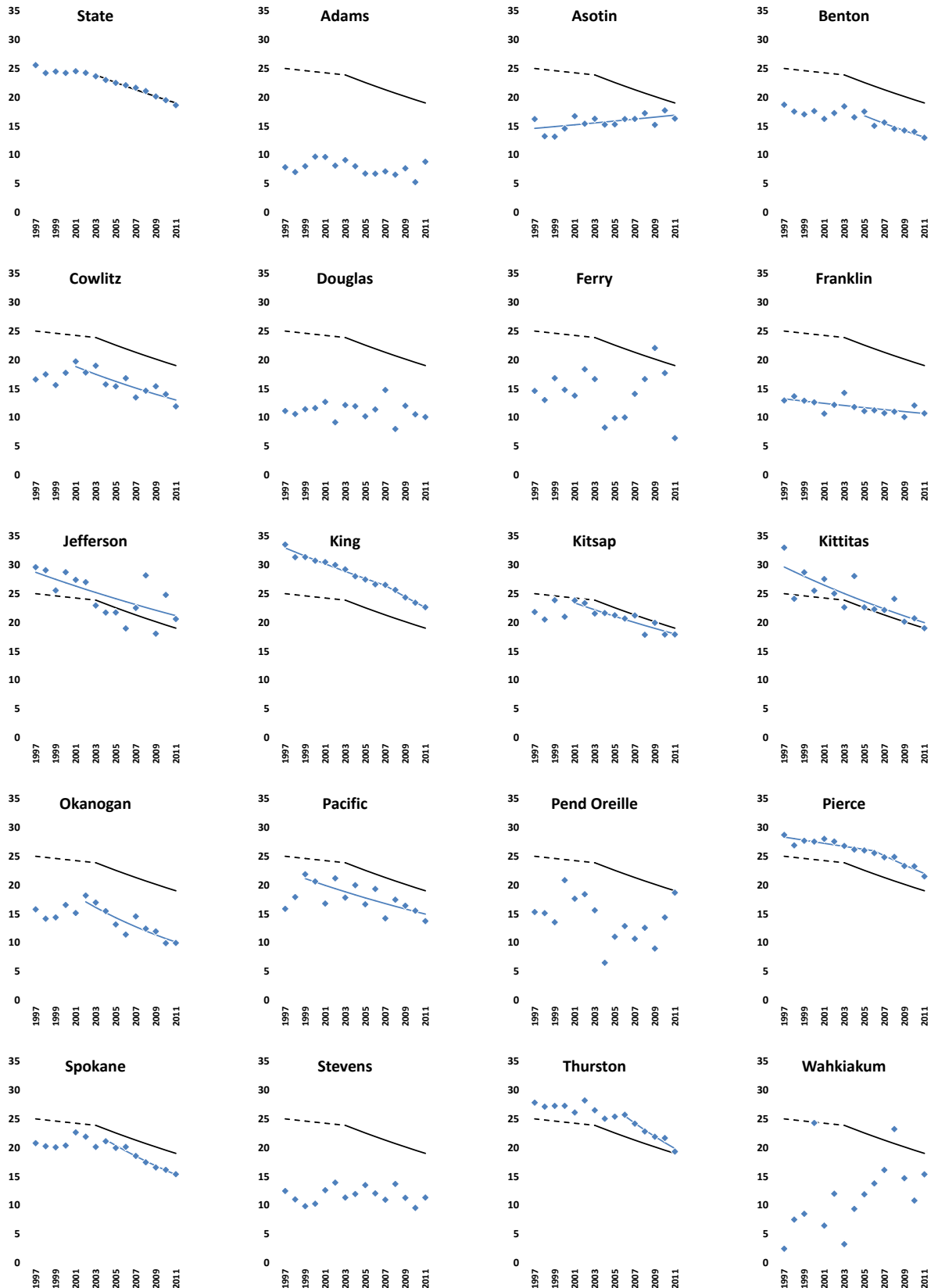




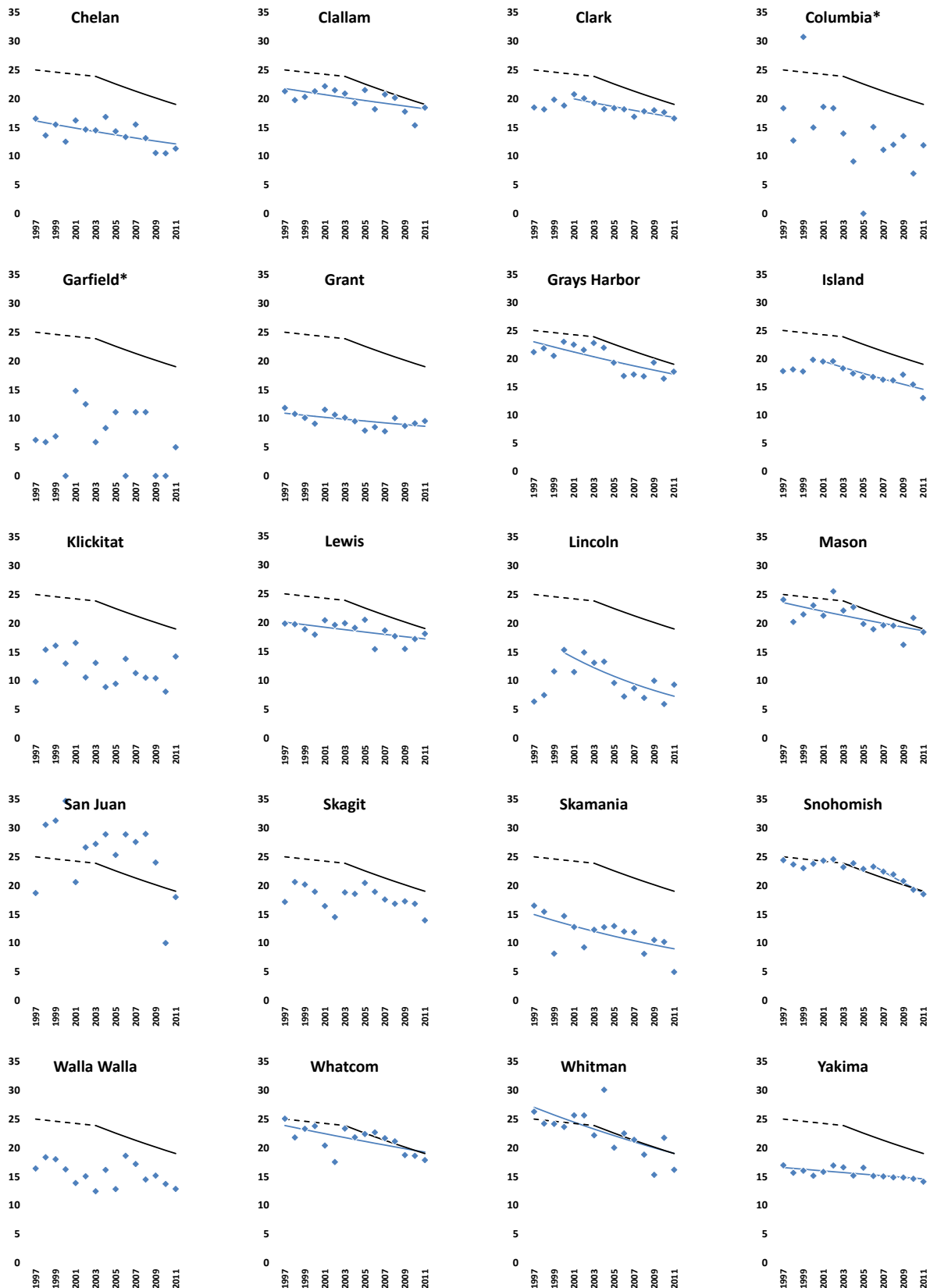
Abortion service flow patterns, county of residence to county of service
2009-2011 combined, DOH

County of Residence	County of Service																		Total
	out-of-state	Benton	Clallam	Clark	Grant	Island	King	Kitsap	Kittitas	Lewis	Mason	Pierce	Snohomish	Spokane	Thurston	Walla Walla	Whatcom	Yakima	
Adams	-	60%	-	-	-	-	<5%	-	<5%	-	-	-	-	7%	-	-	-	29%	100%
Asotin	<5%	6%	-	-	-	-	<5%	-	-	-	-	-	-	77%	-	<5%	-	11%	100%
Benton	<5%	85%	-	-	-	-	<5%	-	-	-	-	<5%	-	<5%	-	<5%	-	10%	100%
Chelan	<5%	<5%	-	-	-	-	47%	-	<5%	-	-	<5%	<5%	<5%	<5%	-	<5%	41%	100%
Clallam	<5%	-	7%	-	-	<5%	28%	44%	-	-	<5%	12%	<5%	-	<5%	-	<5%	-	100%
Clark	60%	<5%	-	39%	-	-	<5%	<5%	-	<5%	-	<5%	<5%	<5%	-	-	-	<5%	100%
Columbia	-	54%	-	-	-	-	8%	-	-	-	-	-	-	-	-	31%	-	8%	100%
Cowlitz	80%	-	-	13%	-	-	<5%	<5%	-	<5%	<5%	<5%	-	-	<5%	-	-	-	100%
Douglas	<5%	<5%	-	-	-	-	35%	-	-	-	-	<5%	-	8%	-	-	-	51%	100%
Ferry	<5%	6%	-	-	-	-	<5%	-	-	-	-	<5%	-	75%	-	-	-	11%	100%
Franklin	<5%	81%	-	<5%	-	-	<5%	-	-	-	-	<5%	-	<5%	<5%	<5%	<5%	13%	100%
Garfield	-	100%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	100%
Grant	<5%	31%	-	-	<5%	-	9%	-	<5%	-	-	<5%	<5%	12%	-	<5%	-	45%	100%
Grays Harbor	<5%	-	-	<5%	-	-	9%	<5%	-	<5%	<5%	23%	<5%	-	60%	-	-	<5%	100%
Island	<5%	-	-	-	-	19%	27%	-	-	-	-	<5%	40%	-	<5%	-	12%	<5%	100%
Jefferson	-	-	<5%	-	-	<5%	40%	43%	-	-	<5%	10%	<5%	<5%	<5%	-	-	-	100%
King	<5%	<5%	-	<5%	-	<5%	91%	<5%	-	<5%	-	6%	<5%	<5%	<5%	-	<5%	<5%	100%
Kitsap	<5%	<5%	-	-	-	<5%	18%	60%	-	-	<5%	18%	<5%	<5%	<5%	-	<5%	-	100%
Kittitas	<5%	<5%	-	-	-	-	21%	<5%	8%	-	-	<5%	<5%	<5%	<5%	-	-	64%	100%
Klickitat	82%	<5%	-	<5%	-	-	<5%	-	-	-	-	-	<5%	-	-	-	-	10%	100%
Lewis	<5%	-	-	<5%	-	-	6%	<5%	-	29%	<5%	13%	-	<5%	46%	-	<5%	<5%	100%
Lincoln	-	-	-	-	-	-	11%	-	-	-	-	-	-	85%	-	-	-	<5%	100%
Mason	<5%	-	-	-	-	-	11%	12%	-	<5%	20%	16%	<5%	-	40%	-	<5%	-	100%
Okanogan	-	<5%	-	-	-	-	18%	-	<5%	-	-	<5%	<5%	61%	<5%	-	-	17%	100%
Pacific	37%	-	-	<5%	-	-	12%	-	-	<5%	-	14%	-	-	31%	-	-	-	100%
Pend Oreille	-	-	-	-	-	-	7%	-	-	-	-	-	<5%	86%	-	-	-	5%	100%
Pierce	<5%	<5%	-	<5%	-	-	19%	<5%	-	<5%	<5%	77%	<5%	<5%	<5%	-	<5%	<5%	100%
San Juan	-	-	-	-	-	-	45%	-	-	-	-	-	10%	-	<5%	-	43%	-	100%
Skagit	<5%	-	-	-	-	<5%	22%	-	-	-	-	<5%	8%	-	<5%	-	67%	-	100%
Skamania	87%	-	-	13%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	100%
Snohomish	<5%	-	-	<5%	-	-	42%	<5%	-	<5%	-	<5%	56%	<5%	<5%	-	<5%	<5%	100%
Spokane	<5%	<5%	-	<5%	-	-	<5%	-	<5%	-	-	<5%	<5%	92%	-	<5%	<5%	<5%	100%
Stevens	-	<5%	-	<5%	-	-	<5%	-	-	-	-	<5%	<5%	88%	-	-	-	7%	100%
Thurston	<5%	<5%	-	<5%	-	-	10%	<5%	-	<5%	<5%	21%	<5%	-	66%	-	<5%	<5%	100%
Wahkiakum	85%	-	-	8%	-	-	-	-	-	8%	-	-	-	-	-	-	-	-	100%
Walla Walla	<5%	53%	-	-	-	-	<5%	-	<5%	-	-	-	<5%	<5%	-	32%	-	8%	100%
Whatcom	<5%	<5%	-	-	-	-	10%	-	-	-	-	<5%	<5%	<5%	<5%	<5%	85%	-	100%
Whitman	<5%	5%	-	-	-	-	9%	<5%	-	-	-	<5%	<5%	75%	<5%	<5%	<5%	<5%	100%
Yakima	<5%	7%	-	-	-	-	<5%	<5%	<5%	-	-	<5%	<5%	-	<5%	-	<5%	88%	100%

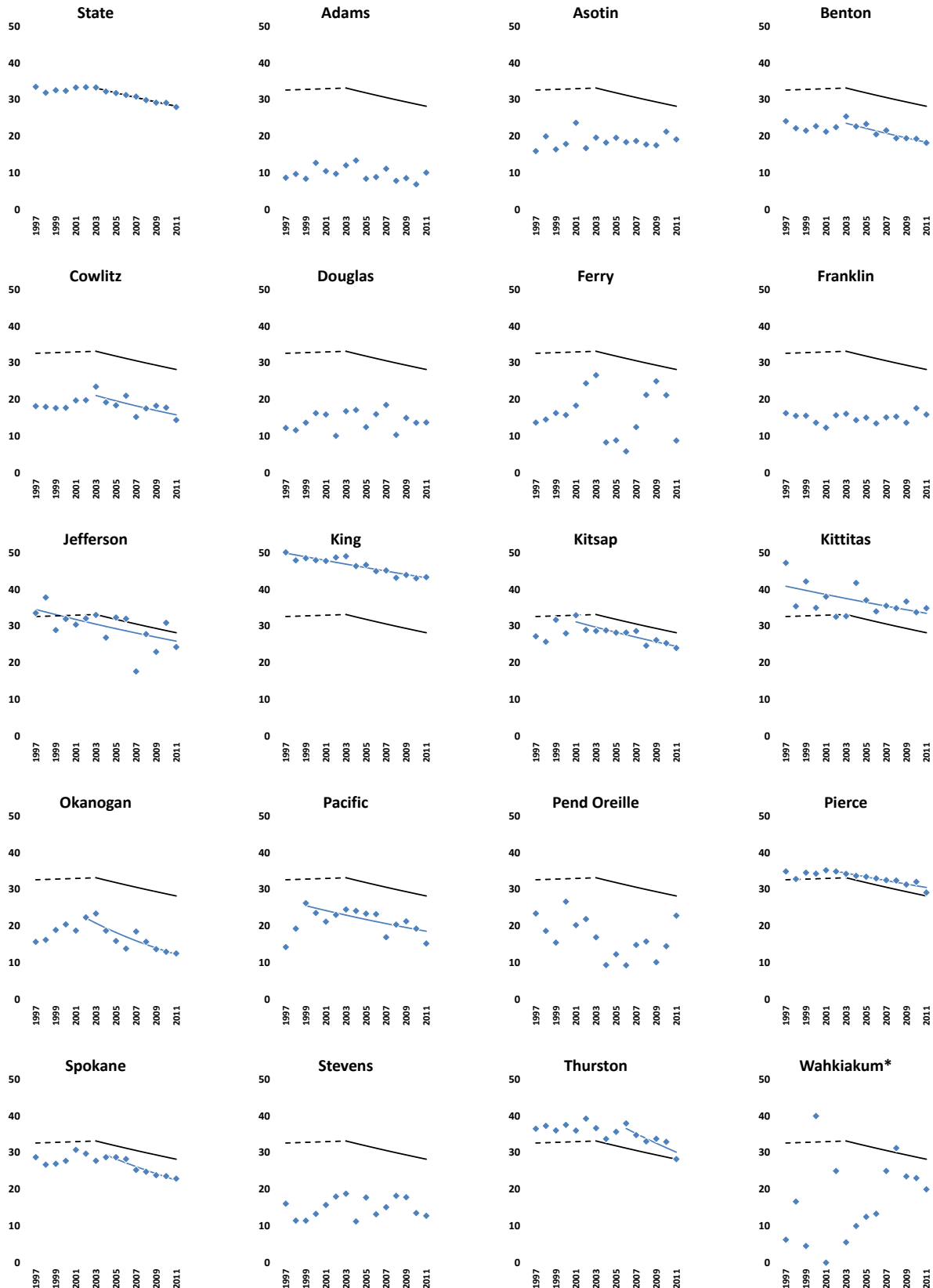
Abortions as a Percent of Total Pregnancies[†] for Women of All Ages



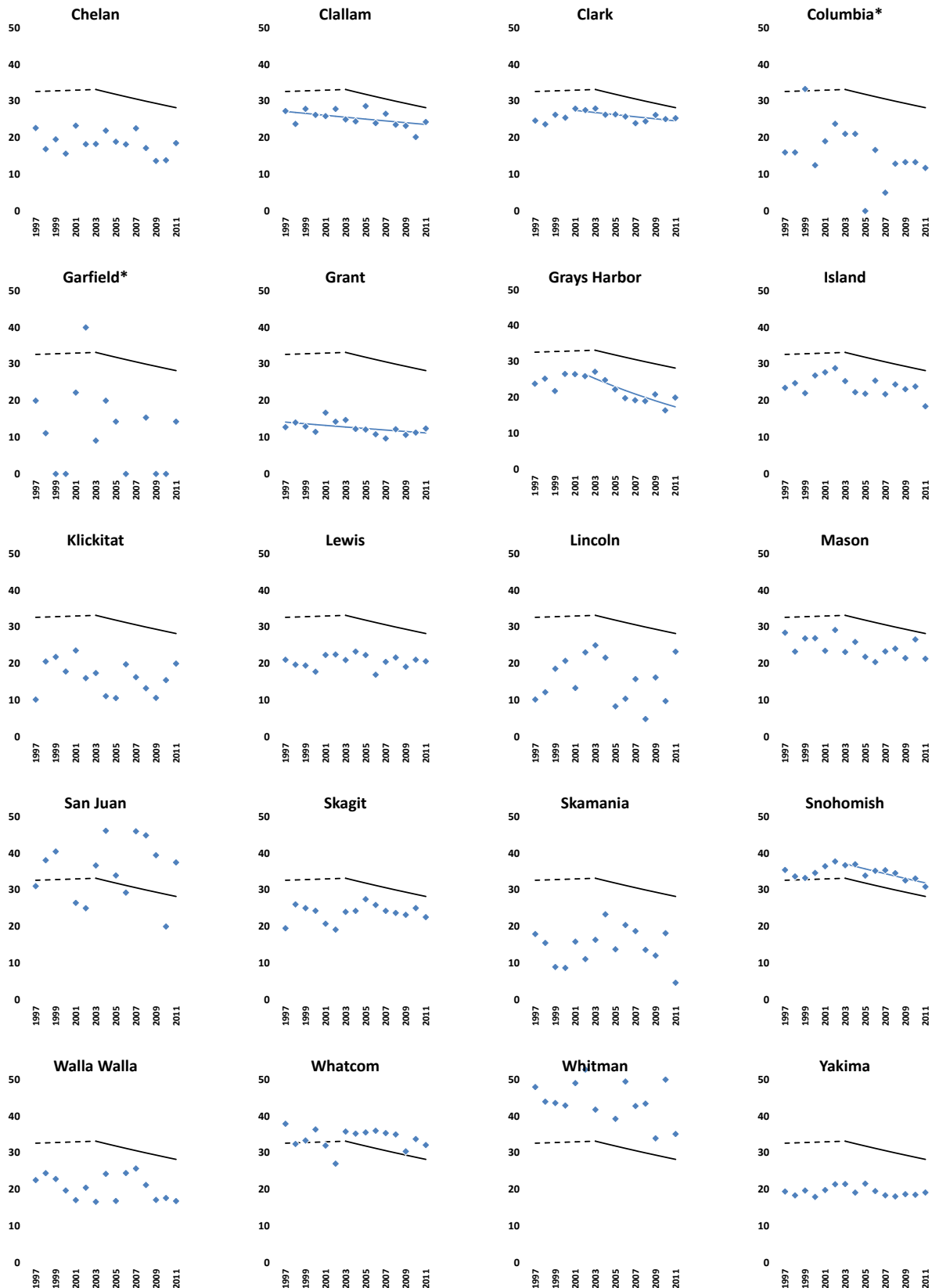
Abortions as a Percent of Total Pregnancies[†] for Women of All Ages



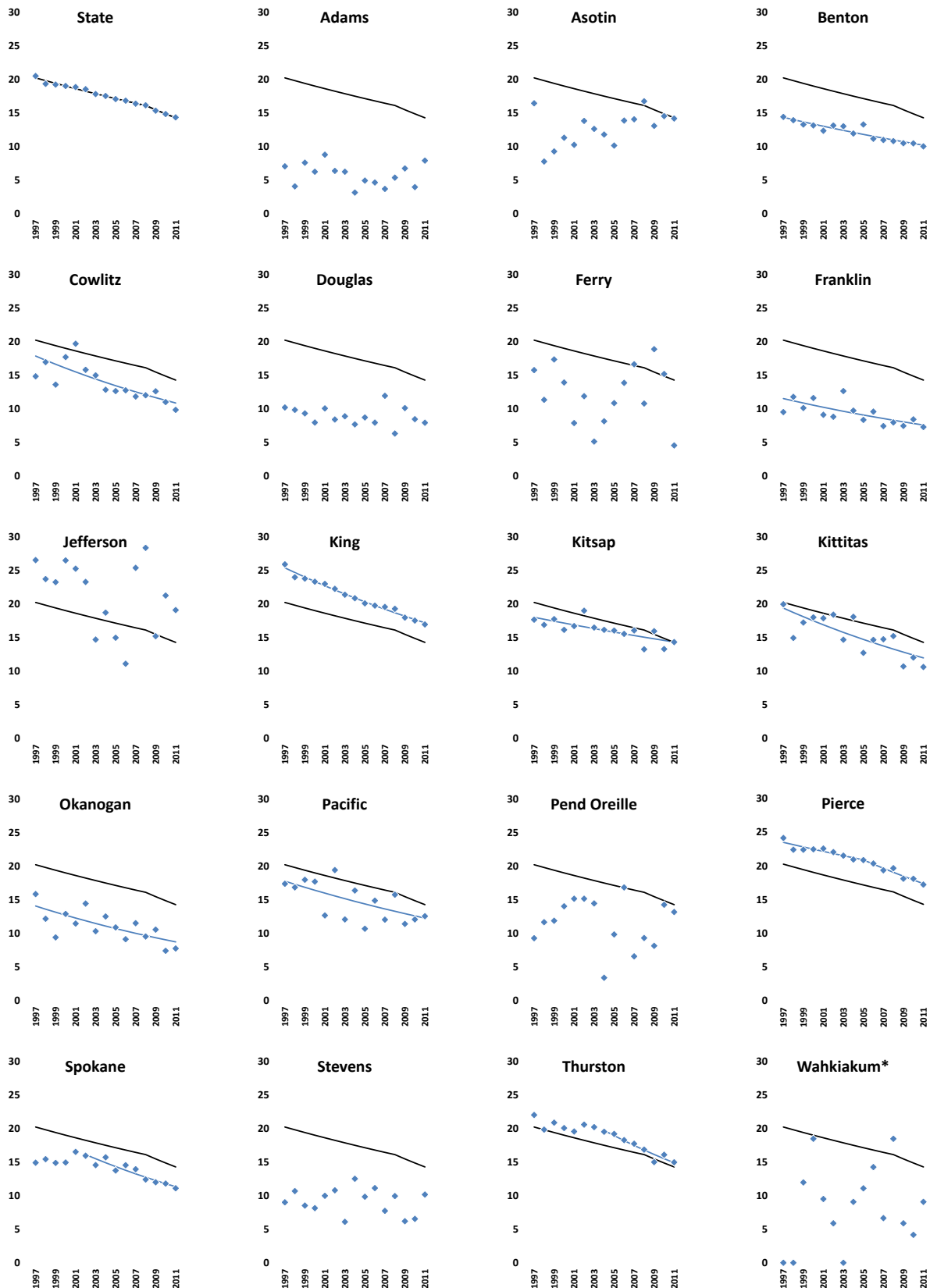
Abortions as a Percent of Total Pregnancies[†] for Women Ages 24 and Younger



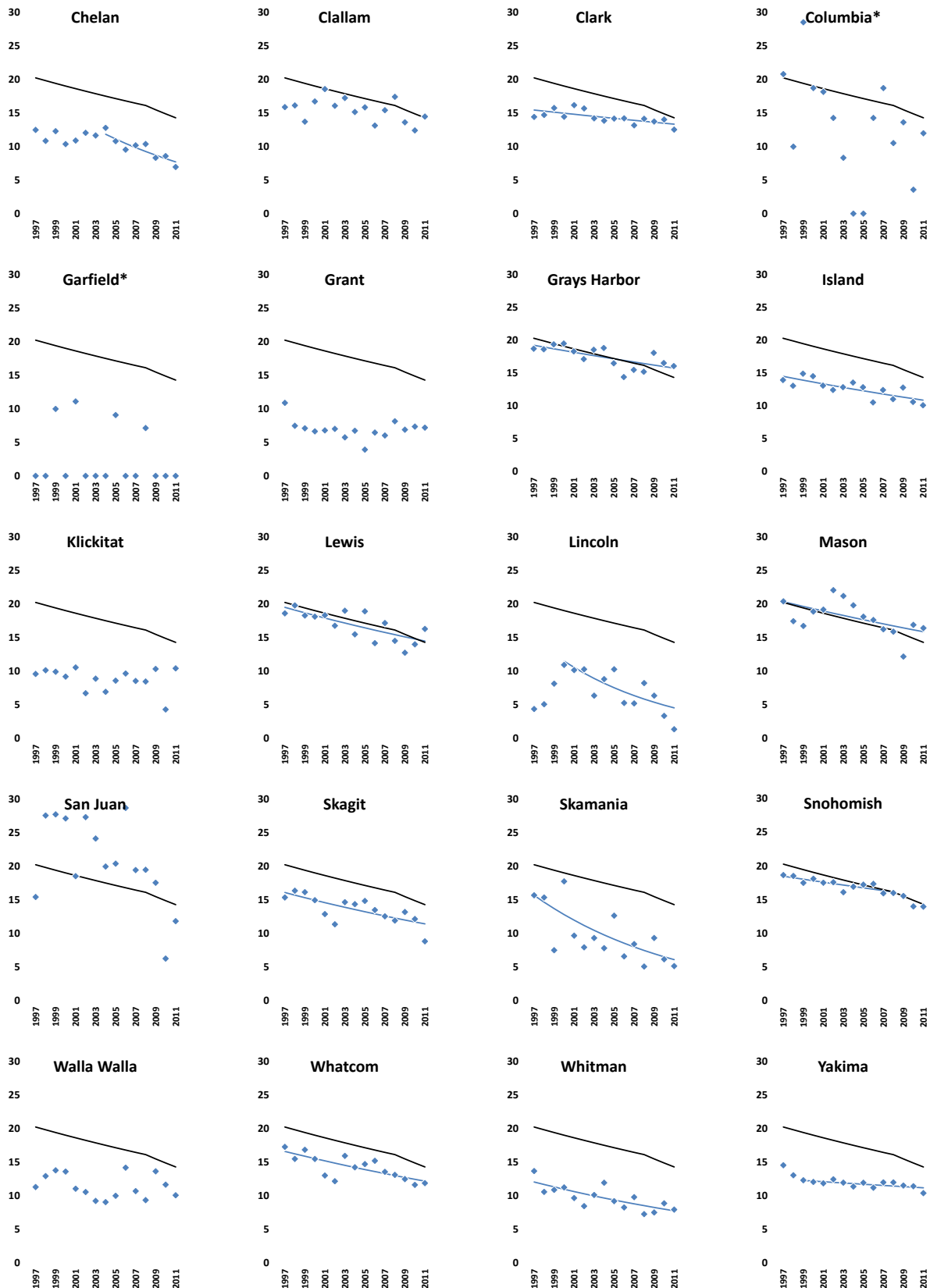
Abortions as a Percent of Total Pregnancies[†] for Women Ages 24 and Younger



Abortions as a Percent of Total Pregnancies[†] for Women Ages 25 and Older



Abortions as a Percent of Total Pregnancies[†] for Women Ages 25 and Older



† Total pregnancies equal the sum of live births, abortions and fetal deaths
* Trends not computed because one or more years had zero abortions.



Washington State Department of Health 2012 Death with Dignity Act Report

Executive Summary

Washington's Death with Dignity Act allows adult residents in the state with six months or less to live to request lethal doses of medication from physicians. In this report, a participant of the act is defined as someone to whom medication was dispensed under the terms of this law. This report describes available information for the 121 participants for whom medication was dispensed between January 1, 2012 and December 31, 2012. It includes data from the documentation received by the Department of Health as of February 28, 2013.

In 2012, medication was dispensed to 121 individuals (defined as 2012 participants):

- Prescriptions were written by 87 different physicians
- Medications were dispensed by 30 different pharmacists

Of the 121 participants in 2012:

- 104 are known to have died
 - 83 died after ingesting the medication
 - 18 died without having ingested the medication
 - For the remaining 3 people who died, ingestion status is unknown
- For the remaining 17 people, no documentation has been received that indicates death has occurred

The 104 participants in 2012 ranged in age from 35 to 95 years old. Ninety percent lived west of the Cascades. Of the 104 participants in 2012 who died:

- 73 percent had cancer
- 10 percent had neuro-degenerative disease, including Amyotrophic Lateral Sclerosis (ALS)
- 17 percent had other illnesses, including heart and respiratory disease

Of the 89 participants in 2012 who died and for whom we have received a death certificate:

- 97 percent were white, non-Hispanic
- 43 percent were married
- 82 percent had at least some college education

Of the 101 participants in 2012 who died and for whom we have received an After Death Report:

- 89 percent had private, Medicare, Medicaid, or a combination of health insurance
- 94 percent reported to their health care provider concerns about loss of autonomy
- 84 percent reported to their health care provider concerns about loss of dignity
- 90 percent reported to their health care provider concerns about loss of the ability to participate in activities that make life enjoyable

Of the 83 participants in 2012 who died after ingesting the medication:

- 89 percent were at home at the time of death
- 92 percent were enrolled in hospice care when they ingested the medication

Death with Dignity Participation in 2012

For the purposes of this report, a participant of the Death with Dignity Act in 2012 is defined as someone to whom medication was dispensed in 2012 under the terms of the act. Details of the act are included in the appendix.

To date, the department has received documentation indicating that lethal doses of medication were dispensed to 121 participants under the law in 2012. These prescriptions were written by 87 different physicians and dispensed by 30 different pharmacists. The department has not yet received all of the required paperwork for all 121 participants. When all the required paperwork is not received, the department contacts health care providers to obtain the documentation.

The Department of Health received the following documentation for 2012 Death with Dignity participants as of February 28, 2013:

Table 1. Documentation Received for 2012 Participants

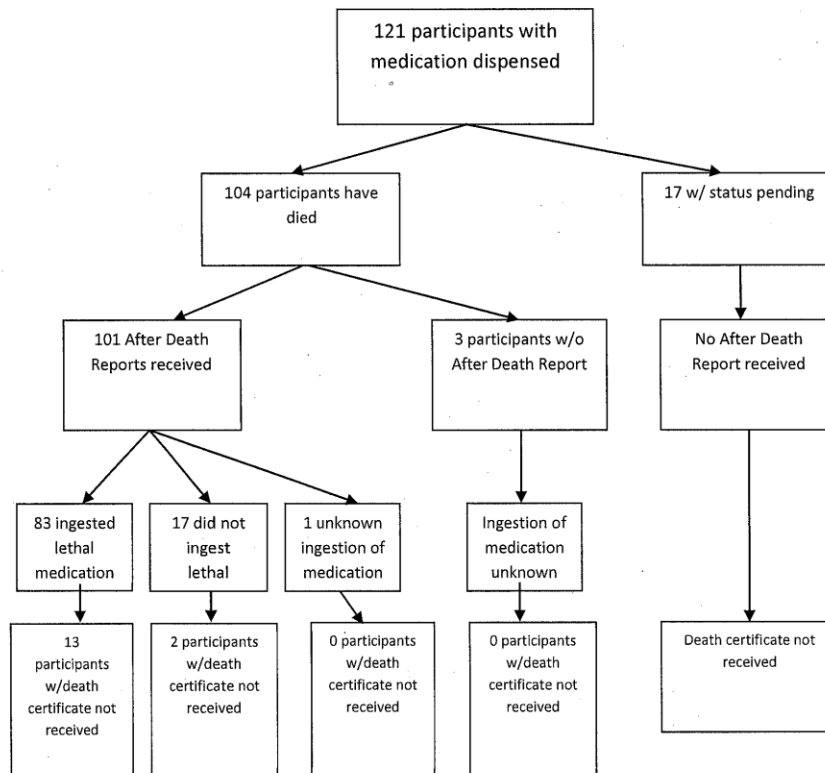
Form	Number
Written Request to End Life Form	111
Attending Physician Compliance Form	112
Consulting Physician Compliance Form	110
Psychiatric/Psychological Consulting Form	3
Pharmacy Dispensing Record Form	117
After Death Reporting Form	101
Death Certificate	89

Table 1 includes the documentation received for individuals defined as participants (people who received medication). The department's Death with Dignity website reports the total number of forms received in 2012, including forms for people who did not have a prescription filled (non-participants), forms for 2011 participants who died in 2012, and some forms for 2013 participants. As a result, the numbers of documents listed in Table 1 do not match the numbers of documents received on the Department of Health website.

Among the 121 participants who received medication in 2012, 83 ingested the medication, 17 did not ingest, and the ingestion status is unknown for 4 (Figure 1). The Department of Health has received notification that 104 of the 121 participants in 2012 have died. Death of a participant is established through receipt of the After Death Reporting form and/or the Death Certificate.


The status of the remaining 17 participants is unknown at the time of this report. Some participants may still be alive since they may wait to use the medication or choose not to use it. It is also possible that some participants have taken the medication and died, but notification has not yet been received by the Department of Health because the After Death Reporting form is due 30 days after death and the Death Certificate is due 60 days after death.


Figure 1. Outcome of the 121 participants who received medication in 2012 under the terms of the Death with Dignity Act





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[Franciscan Does Not Participate In Physician Assisted Suicide](#)

Ethical and Religious Directives

Franciscan does not participate in physician-assisted suicide

Franciscan Health System neither participates in, nor facilitates, physician-assisted suicide. We embrace our sacred duty to provide every patient with the best care possible during his or her remaining life.

Our position is rooted in our faith and in our belief that all life is sacred, from conception to death. We are guided by the *Ethical and Religious Directives for Catholic Health Care Services*.

In addition to compassionate, skilled care for terminally ill individuals, we offer spiritual care and bereavement support for our patients' loved ones.

Health Resources

News and Events

December 14 - Celebration of Life Ceremony

Mimi Pattison, MD, Medical Director receives Business Examiner Distinguished Service Award, watch the video

Franciscan Hospice and Palliative Care expands hospice service to all of King County

Hospice Resources

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 PROVIDENCE Health & Services Washington/Montana	Effective Date: 03/01/2009 New <input checked="" type="checkbox"/> Revised <input type="checkbox"/>	Page 1 of 3
	Subject : Physician-Assisted Suicide	
Authorization: John Fletcher, CEO		

PURPOSE:

To clearly state Providence Health & Services' ("Providence") opposition to and prohibition of its people's participation in physician-assisted suicide, including the use of self-administered life-ending medication as described in the Washington Death with Dignity Act (the "Act"), in any Providence facilities, programs or services in the State of Washington.

SCOPE:

This policy applies to all Providence ministries, employees and volunteers, including all employed and contracted physicians and other professional health care providers while carrying out work-related duties for Providence either within or outside its facilities.

POLICY:

It is our policy that Providence does not participate nor in any way assists with physician-assisted suicide. As we recognize that a patient may seek information or pursue physician-assisted suicide yet never enact it, this policy does not preclude the acceptance of patients who pursue or express an interest in pursuing this option as long as they understand that we will not cooperate in any way in their suicide, including:

1. Providing or securing an "informed decision" as defined by the Act.
2. Providing or completing the written and oral request as provided by the Act.
3. Providing any medication with the specific purpose of ending a human life as contemplated by the Act.

Providence's position and policy are based on its fundamental values of respect for the sacredness of life, compassionate care of dying and vulnerable persons, and respect for the integrity of the medical, nursing, and allied health professions. Providence believes that while individuals are stewards of their lives, we may not unduly prolong nor hasten the natural process of dying.

Providence reasserts its commitment to provide appropriate support for dying persons and their families through the final stages of life including:

1. Providing and supporting patient self-determination through the use of advance directives.
2. Offering hospice, palliative and other supportive care
3. Effective pain and symptom management and other social, spiritual, and pastoral care support and services.

Providence reserves all rights to impose sanctions on any health care provider who has privileges or otherwise is able to practice in Providence's facilities, programs or services consistent with Section 19(2)(b) of the Act, if such health care provider engages in any conduct inconsistent with this policy.

PROCEDURE:

1. Patients, families, nurses, physicians and other providers are encouraged to fully explore and discuss care and treatment options for terminally ill patients. As part of that discussion, we recognize that requests for assisted suicide, physician-assisted suicide, or self-administered life-ending medication will occur within the context of the physician-patient relationship. We respect the rights of patients and physicians to discuss and explore all such treatment options, but fully

Policy Owner: WA/MT Mission and Ethics

expect that patients, physicians and staff will respect the Providence position set forth in this policy while undergoing and providing treatment in Providence facilities, programs and services.

2. Discussion regarding how to pursue physician-assisted suicide is between the patient and his or her physician. When a patient expresses intent to follow through with physician-assisted suicide, the patient must be referred back to his or her attending physician. Nursing and other staff (e.g., Pastoral Care, Social Services, etc.) can continue to provide the patient with effective pain and symptom management and offer emotional and spiritual support as needed. Emotional and spiritual support can also be offered to family members/significant others as needed during this time.
3. When, after discussion with the physician, the patient's desire and intent is to pursue physician-assisted suicide, the patient will be informed that Providence cannot participate or assist with this act in any way.
 - a. While investigating and pursuing physician-assisted suicide as a choice, a patient may stay in our facilities and/or receive ordinary treatment as outlined in the care plan from our staff and physicians.
 - b. The patient should be informed of options for meeting their care needs, including palliative and hospice services for comfort and supportive care as appropriate.
 - c. The patient will be informed that Providence physicians, employees and volunteers will not provide, deliver, administer or assist the patient with the lethal prescription.
 - d. If the patient is in a Providence facility and cannot be transferred, it must be made clear that staff will not participate in any way with the act of suicide.
4. It is anticipated that there will be times when decisions will need to be made on a case-by-case basis based on a patient's specific needs or circumstances. In these cases, employees should contact their local Mission director, who will work with the WA/MT Chief Mission Integration Officer for an ethics consultation.
5. Employed physicians and other Providence-employed health care professionals cannot provide direct provider-to-provider referrals expressly for prescribing a lethal dose of medication.
6. Providence will not dispense or pay for medications for the purpose of physician-assisted suicide.
7. Providence, its hospitals, health care facilities, programs and services shall establish any appropriate procedures needed to fully implement this policy at the facility, clinic, program or service level. All procedures developed at the local ministry level must be approved by the WA/MT Chief Mission Integration Officer prior to implementation.
8. All Providence ministries will update their patient or resident rights to include this statement:

Providence (*insert ministry name*) will not participate in any aspect of physician-assisted suicide including, but not limited to: the provision of information intended to promote physician-assisted suicide; patient assessment for the purpose of eligibility, prescribing, procuring, providing or administering a lethal prescription; or presence when the medication is ingested. Patients who choose to exercise their rights under the Washington Death with Dignity Act will not be excluded from the full range of services provided by Providence (*insert ministry name*).

CONSULTATION SERVICES:

If situations arise that present ethical and/or legal issues the following consultation services are available to any parties involved:

- Ethical Review and Support – Contact WA/MT Chief Mission Integration Officer
- Legal Review and Support – Contact PH&S Office of Legal Affairs

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DEFINITIONS:

1. The term "*Physician-Assisted Suicide*" is defined under Washington Law as a terminally ill informed adult voluntarily choosing to obtain a physician prescription for lethal drugs to end his or her life and self administering the drugs, thereby hastening his or her death following confirmation of a prognosis of death in less than six months. Prior to receiving this prescription, a patient must have a 15-day waiting period, two oral and one written request, a second physician's opinion and counseling if either physician believes the patient has a mental disorder, or impaired judgment from depression. Patients also have the choice whether to notify next of kin or not. Health care providers are immune from civil and criminal liability for good faith compliance.
2. The term "*provider*" means a person licensed, certified or otherwise authorized or permitted by law to administer health care or dispense medication in the ordinary course of business or practice of a profession. For the purposes of this policy, this term includes pharmacists and all individuals providing care to our patients and residents in our ministries.
3. As defined by the American Academy of Hospice and Palliative Medicine, the term "*Palliative Care*", refers to the comprehensive, specialized care provided by an interdisciplinary team to patients and families living with life-threatening or severe advanced illness expected to progress toward dying and where care is particularly focused on alleviating suffering and promoting quality of life. Major concerns are pain and symptom management, information sharing and advance care planning, psychosocial and spiritual support, and coordination of care.
4. The term "*Compassionate Care*" refers to the provision of physical, emotional, mental, spiritual, and social support to patients and families/significant others.

AUTHORIZATION HISTORY:

Original Approval: 03/01/2009

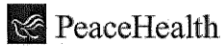
Reviewed / Revised:

Signature on file

John Fletcher, CEO Washington/Montana Region

Date

Policy Owner: WA/MT Mission and Ethics


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Our Catholic Identity

PeaceHealth is a Catholic health care system bringing exceptional medicine to multiple Northwest communities, always with a concern for the most vulnerable, in keeping with our Catholic identity:

- PeaceHealth is committed to serving the poor and vulnerable as reflected in the services we provide.
- PeaceHealth is committed to providing health care services to any person seeking care whether they have health insurance coverage or not.
- PeaceHealth does not permit abortion except to save the life of the mother. Contraceptive decisions are between the patient and the health care provider.
- Emergency contraception is provided to women who are victims of sexual assault.
- RU-486 is an abortifacient and is not dispensed at PeaceHealth.
- PeaceHealth provides high quality compassionate care at the end of life. Withdrawal of medical treatment (e.g. hydration and nutrition, ventilator, pacemakers, antibiotics, and blood products) is appropriate if it is non-beneficial in meeting the patient's goals.
- Physician-assisted suicide is prohibited. Physicians are prohibited from participation in the medical and psychiatric consultations on PeaceHealth time and in PeaceHealth facilities or any facility leased from PeaceHealth.

For additional information, contact a PeaceHealth Director of Ethics.

Updated July 2013

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11/18/2013

Appendix F

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 02-02-38
Baltimore, Maryland 21244-1850



Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group

Ref: S&C: 11-36-Hospital/CAH

DATE: September 7, 2011

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Hospital Patients' Rights to Delegate Decisions to Representatives; New Hospital and Critical Access Hospital (CAH) Patient Visitation Regulation

Memorandum Summary

- **President's Directive:** On April 15, 2010 the President issued a memo concerning hospital visitation and designation of representatives.
- **Clarification of Patients' Rights Concerning Designation of Representatives:** Hospitals are obligated under certain circumstances to extend patients' rights to patients' representatives. The Centers for Medicare & Medicaid Services (CMS) expects hospitals to give deference to patients' wishes concerning their representatives, whether expressed in writing, orally, or through other evidence. Hospital Appendix A is being revised to clarify the applicable requirements.
- **Hospital Visitation Policies:** CMS has amended the hospital and CAH Conditions of Participation (CoPs) to require protection of a patient's right to have and designate visitors. Hospital Appendix A and CAH Appendix W are being updating accordingly.

On April 15, 2010 the President issued a memorandum to the Secretary of Health and Human Services (copy enclosed) directing the initiation of rulemaking to ensure that hospitals respect the right of patients to have and designate visitors. The memorandum also directs the Secretary to issue guidance that clarifies existing regulatory requirements at 42 CFR 482.13, governing the right of a patient's representatives to make informed decisions concerning the patient's care, and 42 CFR 489.102(a), concerning advance directives, such as durable powers of attorney and health care proxies. This Survey & Certification Memorandum provides the clarifications of existing regulations and policy guidance concerning new regulations that fulfill the expectations of the President's memorandum.

Hospital Patients' Rights and Patient Representatives. The hospital CoP at 42 CFR 482.13 establishes a number of requirements regarding patients' rights, several of which may be exercised by or involve representatives designated by patients:

- Notice of the patient's rights must be given to the patient or patient's representative. (§482.13(a)(1))
- Patients (or their representatives) have the right to participate in the development and implementation of their plan of care. (§482.13(b)(1))
- The right to make informed decisions regarding the patient's care may also be exercised by the patient's representative as permitted under State law. This right to make informed decisions includes being informed about the patient's health status, being involved in care planning and treatment, and being able to request or refuse treatment. (§482.13(b)(2))
- The patient has the right to formulate an advance directive, which may include delegation of the right to make decisions about the patient's care to a representative, as well as designation of a support person. The regulation further requires that notice be given to the patient concerning the hospital's advance directives policy. (§482.13(b)(3), which references §489.102)
- A family member or representative of the patient's choice must be promptly notified of the patient's admission to the hospital. (§482.13(b)(4))

CMS expects hospitals to give deference to patients' wishes concerning their representatives, whether expressed in writing, orally, or through other evidence. We are revising relevant portions of the State Operations Manual Hospital Appendix A to clarify CMS's expectations regarding hospitals' recognition of patients' representatives. We are also taking this opportunity to incorporate into Appendix A revisions that were made to the required patient disclosure provisions of Part 489 and that are enforced under §482.13(b)(2). These revisions were discussed in S&C-08-07, December 14, 2007, and S&C-09-25, February 13, 2009.

CAHs and Advance Directives

Sections 42 C.F.R. 489.100, 489.102 and 489.104 of the provider agreement regulations govern advance directive requirements that apply to CAHs as well as to hospitals. When surveyors assess a CAH's compliance with the requirements at §485.608(a), which specify that the CAH must be in compliance with applicable Federal laws and regulations related to the health and safety of patients, they must include evaluation of the CAH's policies, procedures and practices concerning advance directives. We are adding guidance to Appendix W that explains the advance directives requirements CAHs must comply with. We are also updating the guidance for §485.608(a) to incorporate into Appendix W revisions that were made to the required patient

disclosure provisions of Part 489 and that are enforced under §482.13(b)(2), that were discussed in S&C-08-07, December 14, 2007 and S&C-09-25, February 13, 2009.

Hospital and CAH Patients' Visitation Rights

CMS has adopted new standards at §482.13(h) for hospitals and §485.535(f) for CAHs that require hospitals and CAHs to:

- Adopt written policies and procedures concerning patients' visitation rights, including any clinically reasonable and necessary restrictions or limitations on visitation;
- Provide notice to patients or their support persons (where appropriate) of their visitation rights, including the right to receive, subject to the patient's consent, visitors designated by the patient, including but not limited to a spouse, domestic partner (including a same-sex domestic partner), another family member, or a friend. The notice must also advise of the patient's right to withdraw or deny consent at any time;
- Not restrict, limit, or deny visitation privileges based on race, color, national origin, religion, sex, gender identity, sexual orientation, or disability; and
- Ensure that all visitors enjoy full and equal visitation privileges consistent with the patient's preferences.

Attached is an advance copy of the revised Appendix A and Appendix W provisions. The final version will be released as a Publications Manual transmittal at a later date and may differ slightly from this advance copy.

Questions about this guidance should be addressed to Marilyn Dahl at marilyn.dahl@cms.hhs.gov or Georganne Kuberski at georganne.kuberski@cms.hhs.gov.

Effective Date: Immediately. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum.

Training: This policy should be shared with all survey and certification staff and their managers.

/s/

Thomas E. Hamilton

Attachments (2)

cc: Survey & Certification Regional Office Management

