Center For
H·O·P·E
The right choice for all the right reasons

Friends Foundation for the Aging

New Grant Proposal Form

Date: March 15, 2024

Organization: The Center for Hope Hospice & Palliative Care

TIN & Formal organization name: 22-2444824, Center for Hope Hospice, Inc.

Contact name, phone, email:

Frank Brady, President
908.889.7780 – fbrady@cfhh.org

Rich Broski, Director of Communications & Development
908.451.6059 – rbroski@cfhh.org

Amount requested: $30,000

Project title: Supporting our Burgeoning Palliative Care Program

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March 15, 2024

Ms. Susan W. Hoskins LCSW, Executive Director
Friends Foundation for the Aging
PO Box 1081
Langhorne, PA 19047

Dear Ms. Hoskins:

Thank you for allowing the Center for Hope Hospice and Palliative Care in Elizabeth and Scotch Plains, NJ to apply for support. We are very grateful for this opportunity.

We sincerely hope that you will consider supporting this program and becoming a part of the Center's never-ending search for ways to improve the services we provide. As the needs of our patients continue to evolve, the Center's goal is to adapt to and address these needs effectively. It may occasionally appear to be an insurmountable task, but with the assistance of the community, the goal is attainable.

We thank you and the Board, officers, and staff of the Friends Foundation for the Aging for your consideration. If you have any questions or need additional information, feel free to contact me at your convenience.

Sincerely,

Frank Brady, MPA, RN
President

Center For H·O·P·E
Hospice & Palliative Care

Summary Description:

This proposal requests support for our *Palliative Care Program* whose goal is to assist seniors remain independent and mitigate the need for disruptive emergency room visits.

What is the problem you have identified?

Many seniors in our community who are challenged by chronic and often debilitating illnesses face many obstacles finding the support necessary to remain independent. Often, these seniors live alone or with partners who may be equally confused on how to properly care for them. Our current medical system fails them as demonstrated by unnecessary visits to the emergency room, which often exacerbate the problems, rather than alleviate them.

After more than 40 years of providing hospice services in the community, the Center is well aware that questions and concerns about one's health, especially when trying to manage a chronic illness, can arise at any time of the day or night. Traditional medical models do not offer adequate support and an immediate conduit to the information and assistance they need. This often leads to a panic-situation resulting in a 911 call and a trip to the emergency room. The disruption is monumental and even at the emergency room, the usual chaos and long waits add to a patient's and family's frustrations. Many times, this trip is traumatizing and results in an exacerbation of the overriding issues, and not a resolution to them.

Patients and their families face inconsistent policies regarding hospital stays. Hospital systems are implementing increasingly rapid discharges while simultaneously discouraging readmissions due to financial penalties they would incur. The results are patients who are confused and not adequately prepared for a successful transition back to independent living.

Traditional palliative care programs require even essentially homebound patients to seek care outside of the home, creating a barrier to appropriate treatment and adding a sense of stress, or even guilt, onto the patient and/or family. Many programs that only 'treat' the patient medically have been demonstratively inadequate in deterring the very emergency room misuses and rehospitalizations that they are trying to prevent.

Like most problems, the lack of immediate care and medical guidance disproportionately affects the poor, those just above the poverty line and, by definition, the underserved. These patients may have used the emergency room for routine care in the past; unless deterred by another easily accessed resource, they will automatically return to the emergency room.

In summary, there is a lack of existing and appropriate services for this at-risk, underserved population whose unnecessary visits to the emergency room are both disturbing and destructive. Our approach, proven by the exponential growth of the program, addresses these problems and directly meets the expressed needs of this population.

However, as the program has grown, so too have the central expenses associated with it. While many of the services rendered are, in fact, reimbursable or partially reimbursable by Medicare, Medicaid and

private insurances, many of the services associated with the coordination and supervision of the program are simply not covered. As a nonprofit, this fact has created an undue strain on the Center's limited resources.

Our funding request is to help support the program meet the needs of the community over the next 12 months. The Center is currently exploring various options to fund the program. Through a combination of increasing the number of people receiving these services and proving the efficacy of the program's goal of preventing unnecessary rehospitalizations and visits to the emergency room, we're researching governmental funding that would apply to this overall case management and deflection system. Additionally, we are exploring support from major hospital systems as the program will be of a financial benefit (as these systems are punished, within parameters, for the very behaviors that this program inhibits).

The Center's robust Charitable Care Program consumes the majority of the Center's non-operational financial resources. However, we are dedicated to supporting the needs of our community through this important program and finding the proper channels to sustain it into the future.

What is the solution you propose to address the problem?

For more than four decades, the Center has provided patient-centric hospice and palliative care to the communities it serves. Patient needs, expressed directly or through their families, have always guided the Center's efforts, leading to the development of numerous innovations to adequately meet them. The Center's Palliative Care Program is the latest effort to meet the evolving needs of our patients; and, to recognize that as more and more people are living with a chronic illness for a protracted period of time, new and innovative approaches to both the services that are provided and the supports that are necessary need to be made.

As the Center has identified lack of immediate access to appropriate information as being a major cause of unnecessary trips to the hospital, our palliative care program addresses this by tying our palliative care patients to our existing patient response system. This system consists of an awake, on-site nurse available 24/7 to answer any questions and concerns that our patients may have. Typically, our experience is that patients often call with questions about increasing or decreasing their medications; symptom intensification, or general advice about dietary or toileting issues. The responding nurse can use several techniques at his/her disposal to address any concerns that may arise. Please note that this essential and vital component of the program is completely unfunded except for what the Center contributes.

To respond to the need for additional guidance and support, the Center's Palliative Care Program utilizes a case management model that provides both Advanced Practice Nurses and social work services that help tie the patient to existing community resources.

As many palliative care patients are dealing with major medical illnesses, leaving the home, while possible, may present significant difficulties. The Center's Palliative Care Program brings many services directly to where a patient resides. In addition to regular visits from medical professionals, the Center's program provides social workers, chaplains, and volunteers, as well as access to mobile therapies (x-ray, phlebotomy, etc.) that may be of benefit to a patient. Functioning as both advocate and case manager, appropriate palliative care staff will help arrange safe transportation to medical appointments when required; but, will bring into the home as many services as are available and necessary.

Succinctly stated, the goal of our palliative care program is to facilitate the continued independence of seniors in their own homes, while simultaneously ensuring access to timely and proper medical care. This program has helped seniors who have difficulty leaving their homes access the care they need. Additionally, and as important, this program has proven to prevent unnecessary trips to the emergency room and/or hospital stays which are undeniably upsetting and disruptive.

What actions will you take?

The Palliative Care Program is a comprehensive service that utilizes a variety of professionals, including but not limited to Advanced Practice Nurses, chaplains, social workers, and volunteers to support and extend independent living. These professionals can work with the patient and/or their family to access benefits; help arrange care where appropriate; find and understand the need for respite; help coordinate multi-providers and multi-prescribers; and, attempt to intercede with other issues that may threaten a patient's independence.

Patients are referred to the program principally by hospital systems, physician consortiums, individual practitioners, and in some cases, the patients themselves. They are screened for clinical appropriateness by a licensed practical nurse, the Center's full-time palliative care intake worker. If appropriate clinically, a patient's chart is opened and the Advanced Practice Nurse Coordinator assigns the APN and arranges for a visit based on urgency. Subsequent to the evaluation visit, a treatment plan is developed which includes the disciplines that will initially need to be involved and the frequency of visits needed. Patients are reviewed on a regular basis by the APN clinical team to ascertain whether changes to either frequency or disciplines are necessary.

Patients in the Center's *Palliative Care Program* are also linked to our *Patient Response System*, giving them and their families immediate access to a registered nurse who can instantly review their medical record, respond to their questions and concerns, and provide advice. A nurse can also be dispatched (at any time of the day or night, seven days a week) if an in-person home visit would prevent an unnecessary trip to the emergency room. This approach has been highly successful with our hospice patients, and thus far, having this direct access has been a substantial benefit to our palliative care patients and their families.

The program has become an important component of the Center's portfolio of services. In addition to the immense benefits it provides to New Jersey seniors, it serves as a bridge to connect patients and families with proper care. Additionally, the program introduces people to the Center for Hope, its staff, its services, its mission and the often-complex concepts of palliative care and hospice care. Many patients receiving palliative care have made a seamless transition to hospice as their needs change.

The pace of growth the program has experienced has challenged the Center's resources and, at the same time, doubled our commitment to providing this natural expansion of our services.

Describe the population to be served.

The population that will be served by this program is seniors with a chronic illness who are essentially homebound and are at risk of accessing the emergency room and/or the hospital inappropriately due to a lack of community support.

Our palliative care patients benefit from the same patient-centric treatment model that the Center has used successfully for more than 40 years with our hospice patients. This principle dictates that no matter what services are needed, the decision of the patient is final. The dignity of the patient and the family is never questioned by any member of the Center's staff.

Due to the nature of our Patient Response System, the majority of our patients reside within a 45 minute drive from either of our Scotch Plains or Elizabeth facilities.

Are there partners/collaborators for implementation or funding-who? Has the solution been tried by other organizations?

The Center has been a provider of hospice and palliative care services for more than 40 years. In that time, we have forged reciprocal relationships with every major hospital in our area. These include, but are not limited to, Trinitas Regional Medical Center, Rahway Medical Center, Overlook Medical

Center, Jersey City Medical Center, JFK New Brunswick, and St. Peter's. Additionally, the Center maintains a close relationship with Summit Medical Group and a variety of individual medical practitioners that are too numerous to mention individually. As a result of these close relationships, we have collaborated with hospital personnel to ensure that they understand the benefits of the program which accrue not only to the patient, but also for the hospital.

It should be noted that several of our institutional partners use the Center preferentially as our commitment to the under-insured, underserved and under-represented is well known and well respected. While other palliative programs do exist, our program is unique in its approach and exceptional in its benefit to seniors in our community.

How will you know your actions are having an impact? How will you measure outputs and outcomes?

The *Palliative Care Program* will be evaluated from both management and clinical perspectives through:

- Pertinent clinical data points, e.g. age, diagnosis, onset of illness, etc., will be recorded and tracked to further refine our target population and the specific services that would benefit or impact them
- Patients will be tracked in terms of unnecessary visits to the emergency room; and, rehospitalizations related to the health related conditions being managed; these statistics will be compared to relevant national and state statistics as published by the Centers for Medicare and Medicaid Services (CMS); and, our expectations are that patients enrolled in our program will have better outcomes than national statistics indicate
- Surveys will be sent to program participants at the start of service and at its conclusion. Additionally, long term participants and/or their caregivers will be surveyed no less than once a year. The surveys will measure their initial ability to cope with and manage symptoms and problems associated with their health challenges; and, subsequent surveys will be used to determine program effectiveness and direction
- For patients deemed clinically appropriate, statistics will be maintained on the rate and timing of the conversion to hospice, which will be compared to the conversion rates of other palliative care programs

Additionally, every patient is assessed at every visit. Treatment plans and visit frequencies are often changed due to emerging circumstances. The palliative care team reviews patients on a regular basis and any change in circumstance, condition and/or medications are discussed, and plans altered accordingly.

In our 40 year history, we have been blessed with having several community partners who have understood the Center's value and willingly supported our numerous innovations to care over the years. We have never forgotten these partners and have never forgotten our responsibility to be good stewards of the funds they have provided. As we continue to search for ways to improve the services we provide, community partners such as the Friends Foundation for the Aging become vital to the continuing success of our mission and its effects on the community. We thank the Foundation for taking the time to consider the Center as a worthy partner.

PERSONNEL	12 Month				
POSITION	**FTE = 40 HOURS PER WEEK**	**RESPONSIBILITIES**	**FUNDED BY MEDICARE/COPAY**	**CENTER'S SHARE**	**TOTAL COST**
DEDICATED PALLIATIVE CARE INTAKE WORKER	100% 40 HOURS PER WEEK	Receives and evaluates clinical information obtained from referral sources; conducts initial assessment of paperwork for appropriateness; opens chart; assigns APN assessment visit and/or RN visit if necessary	N/A	$66,500	$66,500
ADVANCED PRACTICE NURSE COORDINATOR	100% 40 HOURS PER WEEK	Reviews clinical information; conducts in-person initial medical assessment; designs treatment plan with patient and family; coordinates the exchange of medical information between or among other provides and prescribers; presents case at team meetings; assigns APNs for ongoing treatment; assists with supervision of APNs	15 medical assessments inperson per week; reimbursed at approximately $100 per visit = $78,000	$42,000	$120,000
ADVANCED PRACTICE NURSE CASE MANAGER(S) (APN)	1 FTE PER 40 PATIENTS 3 FTEs	On going case and symptom management accomplished through, at a minimum, one in person APN reassessment; and, at a minimum 2 telephone (audio or audio visual) calls per month. APNs present achievements, challenges and changes to patient's condition or circumstances at team meetings	Average 15 visits per week; $100 reimbursement per visit.= $1500 per FTE per week. Total Reimbursement for 3 FTEs: $234,000	$81,000	$315,000
LICENSED CLINICAL SOCIAL WORKERS (LCSW)	100% = 40 HOURS PER WEEK	LCSWs are assigned by either the APN Coordinator or the APN Case Manager. LCSWS are provided to assist with any dynamic that interferes with the appropriate management of the patient's needs; and/or to help access benefits that will improve the patients physical, social and/or financial circumstances	Average 15 visits per week: $100 reimbursement per visit = $78,000	$17,000	$95,000

REGISTERED NURSES (RN)	1 FTE PER WEEK	RNs staff the Center's Patient Response System to which our palliative care patients may access for immediate advice or counsel; RNs are dispatched to patients homes when necessary.	N/A	$90,000	$90,000
RN PROGRAM SUPERVISOR	5% = 2 HOURS PER WEEK	Monitors the overall performance of the program. Chairs weekly teams meetings; provides direct supervision when needed; represents the needs of the program at community events and Executive Management meetings.	N/A	$132,600 / 2080 = $63.75 per hour x 104 hours = $6,630	$6,630
DIRECTOR OF NURSING (DON)	1% = 1 HOUR PER WEEK	Develop, distribute and monitor policies and procedures that meet all applicable federal and state regulations regarding the on-going implementation of the Palliative Care Program.	N/A	$132,600 / 2080 hours = $63.75 per hour x 52 hours = $3,315	$3,315
Fringe (14.22%)		(Required benefits, including health where applicable)		$54,241	$54,241
TOTAL PERSONNEL COST			**$390,000 REIMBURSEMENT FROM MEDICARE/CO-PAY**	**$360,686**	**$750,686**
OTHER THAN PERSONNEL EXPENSES (OTPE)					
BILLING COMPANY					$19,500
EQUIPMENT	4 IPADS; 4 MOBILE PHONES; 1 LAPTOP			$5,800	$5,800
TELEPHONE/ COMMUNICATION	$50 PER MONTH X 4 X12				$2,400

TRAVEL	130 MILES PER WEEK PER CASE MANAGING NURSE @ $.55 PER MILE				$11,154
AGENCY OVERHEAD @ 10%	ADMINISTRATIVE OVERSIGHT; INSURANCE; AUDIT; FINANCE ETC.				$75,069
TOTAL OTPE					**$113,923**
TOTAL					**$864,609**
The Center is seeking $30,000 from the Friends Foundation for the Aging in support of our palliative care patients' ability to access RN advice and counsel 24 hours a day/7 days a week.					
This feature is critical for the success of the program's goal of preventing unecessary rehospitalizations and trips to the emergency room as a primary source of care.					

IRS Department of the Treasury
Internal Revenue Service
Cincinnati Service Center
CINCINNATI OH 45999-0028

In reply refer to: 1021421935
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CENTER FOR HOPE HOSPICE INC
% CENT
1900 RARITAN RD
SCOTCH PLAINS NJ 07076-2963

001153

Employer ID number: 22-2444824
Form 990 required: Yes

Dear Taxpayer:

We're responding to your request dated Jan. 02, 2024, about your tax-exempt status.

We issued you a determination letter in 198309, recognizing you as tax-exempt under Internal Revenue Code (IRC) Section 501(c)(03).

We also show you're not a private foundation as defined under IRC Section 509(a) because you're described in IRC Section 509(a)(2).

Donors can deduct contributions they make to you as provided in IRC Section 170. You're also qualified to receive tax deductible bequests, legacies, devises, transfers, or gifts under IRC Sections 2055, 2106, and 2522.

In the heading of this letter, we indicated whether you must file an annual information return. If you're required to file a return, you must file one of the following by the 15th day of the 5th month after the end of your annual accounting period:

- Form 990, Return of Organization Exempt From Income Tax
- Form 990EZ, Short Form Return of Organization Exempt From Income Tax
- Form 990-N, Electronic Notice (e-Postcard) for Tax-Exempt Organizations Not Required to File Form 990 or Form 990-EZ
- Form 990-PF, Return of Private Foundation or Section 4947(a)(1) Trust Treated as Private Foundation

According to IRC Section 6033(j), if you don't file a required annual information return or notice for 3 consecutive years, we'll revoke your tax-exempt status on the due date of the 3rd required return or notice.

You can get IRS forms or publications you need from our website at www.irs.gov/forms-pubs or by calling 800-TAX-FORM (800-829-3676).

If you have questions, call 877-829-5500 between 8 a.m. and 5 p.m., local time, Monday through Friday (Alaska and Hawaii follow Pacific

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CENTER FOR HOPE HOSPICE INC
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SCOTCH PLAINS NJ 07076-2963

time).

Thank you for your cooperation.

Sincerely yours,

Steve M. Brown, Operations Manager
Operations 3-CIN