Friendly Home Visitors
Report-September 2021

1. **What problem were you addressing?**

To combat the issues of social isolation and depression among older adults, Trinitas implemented Friendly Home Visitors (FHV) as part of our Transitional Care (TC) Program that provides at home support to recently discharged chronically-ill patients at high risk for hospital readmission. Social isolation and loneliness among older adults are associated with poor health, depressed mood, decreased quality of life and an increased likelihood of hospitalization or nursing home admissions. In addition, low-income people and ethnic minorities are more susceptible to isolation due to limited resources. FHV utilizes Community Health Workers (CHW) who provide weekly at home visits to TC patients, identified as at risk of social isolation. CHWs spend 2-3 hours per week for about 3 months to provide companionship, play cards, games or puzzles, help with food shopping and give reminders about medications and doctor appointments. Due to COVID, there were several months during 2020-21 that CHWs could not provide in-person visits and instead used FaceTime or phone calls to connect with patients.

2. **What change did you expect to create? How? What were the desired objectives, outcomes and outputs of the program and progress made toward each during the reporting period?**

By providing at-home visits to patients identified as at risk of social isolation, the goal of the program is to reduce depression and feelings of isolation and improve medication and doctor appointment adherence which in turn improve health outcomes and reduces the likelihood of hospital readmission. The program utilizes Community Health Workers (CHW) who work in coordination with our TC team to provide participants with weekly home visits to provide companionship through conversing, playing cards and games, doing puzzles, etc. and provide assistance/reminders about medications and doctor appointments. They also help participants monitor blood pressure and blood glucose, if applicable, and can alert the APN if there is an abnormal reading. In addition, if needed, CHWs help with food shopping, preparing meals and ensure meals are not missed. Having CHWs visit patients shortly after discharge and for a sustained period of time – three months on average –is important during the critical first few weeks and months after discharge when medication adherence and follow-up doctor appointments are vital to a patient's successful recovery at home. In addition, due to the COVID pandemic, the scope of services that the CHWs provided was expanded to include weekly check in calls to discharged COVID patients, and patients who were tested for COVID at the hospital. To assess the effectiveness of the program, patients completed the Patient Health Questionnaire 9 (PHQ-9), a standardized screening tool used to gauge feelings of depression at their first, mid, and final visits. A total of 348 COVID patients (discharged and tested) and 28 TC patients were served. Results from tools used to assess the program show that patients had decreased feelings of loneliness/isolation, improved mood and medication adherence with fewer missed meals and doctor appointments. Based on the results of PHQ-9, out of 28 patients, 21 had a decrease in their scores. We also tracked hospital readmission and only 3 of the 28 (10.7%) patients were readmitted (all due to COVID). This compares to a readmission rate of 15% for all TC patients.

3. **How did you measure success--both quantitative and qualitative? A chart of objectives, actions, and results is helpful. Include numbers and demographics of people touched by the work. Explain your organization's efforts toward diversity, equity and inclusion.**

As noted, we utilized the PHQ-9, a standardized screening tool used to gauge feelings of depression to assess effectiveness of the program. The below chart (labeled Depression) shows the change of the PHQ-9 results. We also used an informal questionnaire to gauge need for meal, medication and doctor

appointment reminders (see Needs chart). The Logic Model below summarizes the inputs, activities, outputs and outcomes and two charts show patients by age and ethnicity.

4. **Please note any collaborations that supported your work and/or ways that you leveraged resources. How did this project engage and empower staff from all levels of your organization?**
   The TC program partners with several social service organizations in Elizabeth and Union County including St. Joseph's Social Services in Elizabeth for free medication, clothing and food for the Elizabeth residents, Community Food Bank of NJ who provide a week of healthy meals for TC participants upon discharge from the hospital, and Community Pharmacy who provides deep discounts for medications for TC patients. We explored ways to partner with Jewish Family Services in Elizabeth to offer their programs to our patients but due to COVID many of the programs are virtual though zoom, which most of our patients do not have access to, so we were not able to utilize the services. We also connected with Rutgers Graduate School of Social Work and secured a graduate student seeking a field placement for the 2021/2022 school year.

5. **Please share any unanticipated outcomes or barriers encountered. Indicate any changes in the program's goals, strategies, personnel or timelines and the reasons behind the changes.**

The main challenges resulted from the coronavirus pandemic. During Spring 2020 and later in 2020 CHWs could not visit patients in their homes and instead phone calls and FaceTime were used to communicate with patients. When the CHWs were able to visit in person, full PPE was required. Staffing challenges resulted as well with one CHW not working for a few months in Spring 2020, due to health issues and COVID. She came back after the surge but later became very ill in April 2021 and left the position due to medical reasons. A new F/T CHW was hired in May 2021. Subsequently, the P/T CHW resigned in August 2021 so we currently have one F/T CHW. Despite these challenges, the program was still effective. Out of 28 patients, only 3 were readmitted- all due to issues with COVID.

In addition, due to the COVID pandemic, the scope of services that the CHWs provided was expanded to include weekly check in calls to discharged COVID patients, and patients who were tested for COVID at the hospital. CHWs were also instrumental in making sure patients who wanted the COVID vaccination, received it by arranging transportation and scheduling appointments.

6. **How do you plan to share and replicate your results?**

Thanks to Friends, we connected with the Rutgers Graduate School of Social Work and secured a graduate student seeking a field placement for the Fall 2021-Spring 2022 school year. The intern started August 31, 2021. Her work will include assessing the impact of the FHV program as well as the TC program overall with respect to hospital readmission rates. In addition, she will research and identify other TC and FHV programs to assess and learn from them as to what works/doesn't work. This will be compiled into report on the FHV program and the TC program, assessing the program, its successes, challenges, etc. and the impact on readmission rates.

7. **Include a project financial statement (budget and actual) for the reporting period.**

Item	Description	Budgeted Cost	Actual Cost
Community Health Workers	2 part-time CHWs: 20 hours per week @ $15 per hour=2*$15/hour*20 hrs/wk*52 wks = $31,200	$39,000	$ 17,000
Mileage	Mileage at $.56 per mile: 2 x $.56/mile x 50 miles/wk x 52 wks=$2,912	$2,912	$ -
Phone	$54/mo : 2 x $54/mo x 12 mos= $1,296	$1,296	$ -
TOTAL		**$43,208**	**$ 17,000**

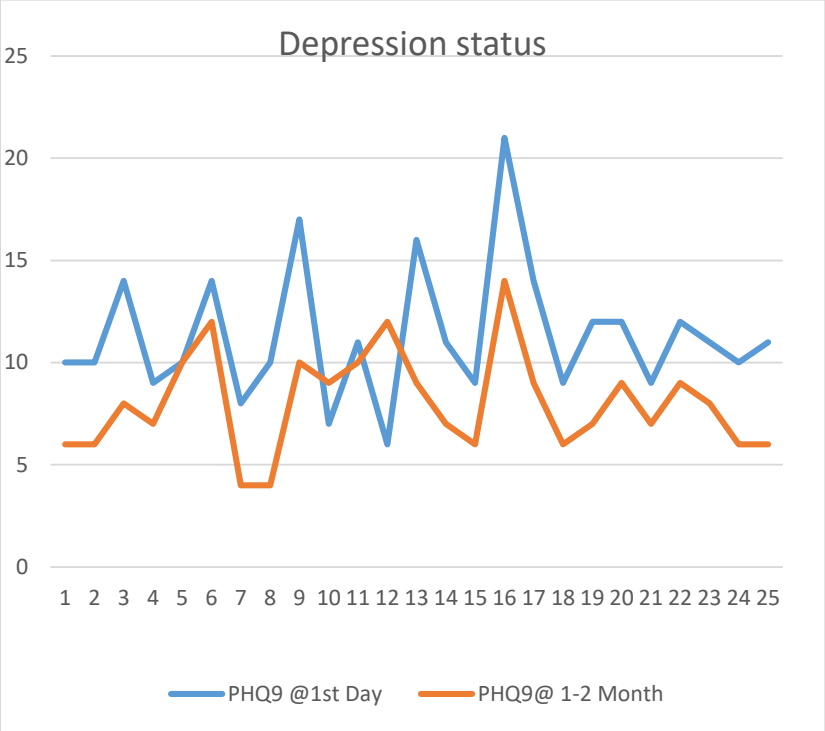
Grant funds remain due to COVID-19 and the impact that it had on staffing for the program. Grant funds have been used to fund salaries as of May 2021 and will continue to fund salaries until all funds are expended. In addition, as CHWs were limited and/or restricted regarding home visits, the budget items for mileage and phone were reallocated to cover salaries. In addition, one of the CHWs initially hired, left the position in April 2021 due to medical reasons and a full-time CHW subsequently joined in May 2021. From May 2021 forward the FHV program was staffed by one full-time (with benefits) and one part-time CHW. Subsequently, in Mid-August the part-time CHW resigned due concerns with COVID and desire to retire. Since that time and going forward, FHV will be staffed with one full-time CHW. We are requesting additional funding from Friends to continue the program for another year as we have had successful results.

8. **Feedback on your interaction with FFA would be helpful. How have we helped? Made it harder? What else can we do to facilitate your work?**

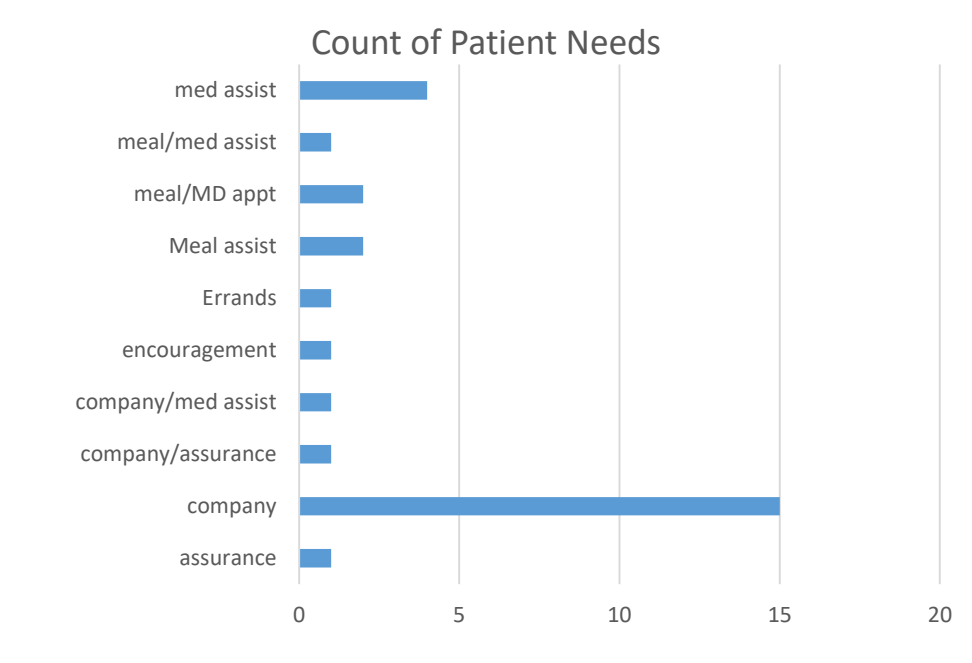
We truly appreciate all of the feedback, guidance and help that Friends provides – from helpful suggestions on grant proposals, to sharing information about similar programs, to facilitating connections to other organizations. We are grateful for the connection to Rutgers and are very excited to have a Rutgers MSW to be interning for the 2020/21 school year. We also appreciate the open dialogue and opportunity to ask questions and provide updates during the grant period. Friends Foundation for the Aging is a true partner and it is through your support that we have been able to first create and then expand and improve this program, providing our patients with the best chance of recovering fully at home.

9. **Additional Comments:** We appreciate the continued support from Friends Foundation for the Aging for our Readmission Reduction program and for caring about our elderly patients!

PHQ-9 Results



Patient Needs



LOGIC MODEL –FRIENDLY HOME VISITORS

Community Health Workers made weekly at-home visits or calls to patients. The visits lasted 2-3 hours and each patient received 12 or more visits, depending on their need. A total of 28 patients were served. They also made follow-up phone calls with patients as needed. Below is the logic model showing inputs, activities, outputs and outcomes.

Inputs	Activities	Outputs	Outcomes
• Staffing-Two part-time Community Health Workers and support from Trinitas' TC team • Funding • Materials –cards, board games, puzzles, arts and crafts, books, harmonicas (for COPD patients), etc.	• CHWs made weekly at home visits or phone calls to patients at risk of isolation. Each patient was seen for 12 weeks or more. • CHWs provide companionship, which included doing puzzles, play games, etc. They also provided assistance/reminders about medication, doctor appointments and ensured meals were properly prepared and eaten. • CHWs helped participants complete survey at first, mid-cycle and final visit. • CHWs followed up with phone calls and additional visits throughout the year, as needed.	• 28 patients served with weekly home visits or phone calls for 12 or more weeks. • CHWs spent 24-36 hours with each patient during the 12 week sessions • CHWs provided a total of about 336 patient visits during the year. • CHWs also did follow-up calls with discharged COVID patients and patients tested for COVID at the hospital who were not admitted -348 patients in total.	After visits with CHWs participants had: • Decrease in feelings of loneliness and isolation • Improved mood; feeling less sad and depressed • Improvement in quality of life shown through interest in doing things like hobbies, games, etc. • Improved medication adherence • Fewer missed meals • Fewer missed doctor appointments • Overall hospital readmission rate for 28 patients was 10.7% which compares to an overall rate of 15% for all TC patients. Note that the 3 readmissions were all due to COVID related symptoms.

Number of Patients by Age and Ethnicity