TRINITAS
HEALTH FOUNDATION

# Friends Foundation for the Aging - Returning Grantee Application September 2021

1. **Has the identified problem changed?**

Trinitas Health Foundation is requesting a $28,000 grant to support two components of the Readmission Reduction program. The problems that the grant will support have not changed but grant funds have helped to improve outcomes for our patients so we are asking for continuing support for the program. One component of the RR program that grant funds will support is the continuation of the Friendly Home Visitors program that works to combat depression and isolation with seniors through the use of at-home visits by a Community Health Worker. We will continue with one full-time CHW and grant funds will support the salary and benefits for this position so that we can continue the program through November 2022. The other need that grant funds will support is medication gap coverage for low-income and uninsured/underinsured patients age 60 and over. For chronically-ill elderly patients there is an immediate need for medication upon discharge from the hospital. Grant funds will cover the cost of medications for patients who are underinsured, uninsured or who can't afford prescription copayment, until they can be set-up to receive free or low-cost medications from other sources. This typically takes between 1-2 months. Often these patients go without medications for their chronic illness, putting them at risk for hospital readmission.

2. **Have your objectives changed?**

Our objectives have not changed. The Readmission Reduction program has been operating at Trinitas since 2013. The program provides at home support to recently discharged chronically-ill patients at high risk for hospital readmission to ensure their long-term recovery at home and reduce hospital readmission. The objective of the grant funding is two-fold. For the Friendly Home Visitors program, the CHW till provide weekly at-home visits to seniors identified as at risk of social isolation in order to alleviate loneliness and decrease feelings of depression and to provide support and reminders about meals, medications and doctor appointments with the objective to improve patients at-home recovery and health outcomes and reduce hospital readmission. On average the CHW will have 8 patients that she will be visiting and following up with weekly for three months each. We expect that about 32 patients will be provided with weekly visits for a period of three months for a total of 12 visits each during the grant funded period. Second improve patient outcomes and reduce readmissions by providing prescription medications for those patients who are uninsured or who need financial assistance to cover prescription copayments, from time of discharge until the patient can receive medications from other sources such as St. Josephs Social

Services for Elizabeth residents and/or prescription assistance programs provide by some pharmaceutical companies.

3. **Will your efforts/actions to impact the problem change? Describe.**

The Friendly Home Visitors activities and goals will remain the same but we will have one full-time CHW providing at-home visits and support instead of one F/T and one P/T. Recently the part-time CHW resigned and the program's APN is looking to continue the program with just one full-time CHW. The CHW will provide companionship through conversing, playing cards and games, doing puzzles, hobbies and reading. This includes identifying interests and hobbies and working with the social worker to connect patients to outside programs for sustained socialization. Another important role for the CHW is to provide assistance/reminders about medications and ensure that follow-up doctor appointments are attended and made. This will help ensure compliance with post-discharge protocols and improve patient outcomes and lower readmissions as non-compliance with medications and doctor appointments is associated with an increased risk for readmission within 30 days of discharge. The CHW can also help participants monitor their chronic illness by assisting with taking blood pressure and blood glucose, if applicable and can alert the APN if there is an abnormal reading. In addition, if needed, CHWs make sure meals are eaten and will help with food shopping, if needed, ensuring that patients choose the proper foods for their chronic illness, and also help them to prepare meals. We will continue to use the PHQ-9 to assess the patient's level of need and level of depression and will complete the PHQ-9 at the first, mid and final visits. For the prescription coverage, actions to address the problem remain the same. Patients who are in need of prescription assistance will be identified prior to discharge and the social worker who is part to the RR team will work with them to enroll in pharmaceutical medication assistance programs, if available and/or get free medications through our partnership with St. Joseph's Services or other available resources. For eligible patients, the social worker will help to apply for Medicaid and/or Medicare

4. **How will you know if the program is successful?**

For Friendly Home Visitors, the CHW will help participants complete the PHQ-9 Questionnaire, at the first, middle and last visit to assess the effectiveness of the program. The PHQ-9 form is a standardized screening tool used to gauge feelings of depression. In addition, a questionnaire is used to assess how often the patients miss meals, medications and doctor appointments to determine if the patient needs reminders or support in any of these areas. The CHW also acts as a "second set of eyes" on the patients and alerts the program's APN if they detect anything of concern. Success will be measured by improvements in PHQ-9 scores over a period of approximately 12 visits by the CHW. A decrease in the score indicates an improvement in feelings of loneliness and depression for the patient. We will also note if there are improvements in medication adherence and fewer missed doctor appointments and meals. We will also track the readmission rate for patients participating in the FHV program and compare to the rate overall for the RR program. We expect to serve about 32 patients annually through the FHV program. For the medication gap coverage, overall we expect that patient outcomes and hospital readmission will improve and that life changing events such as strokes, heart attacks and diabetic events will decrease as patients will be more likely to adhere to medical protocols. The 30-day readmission

data for patients receiving medication assistance will be tracked as well. We expect to assist about 100 patients with medication gap coverage, improving their health outcomes and reducing hospital readmissions.

5. **Program Budget**

We are seeking a grant in the amount of $28,000 that, combined with remaining grant funds, will support the Friendly Home Visitors program and prescription gap coverage for a year. As of November 1, we expect to have about $19,000 remaining in grant funds from the 2020 grant that we received for the Friendly Home Visitors program. These funds as well as new grant funds, if awarded, will support the Friendly Home Visitors program until November 2022 and will support medication coverage for about 100 patients annually during the grant period.

**Program Budget**

| **Item** | **Description** | **Total Cost** |
|---|---|---|
| Community Health Worker Salary- Friendly Home Visitors program | 1 full-time CHWs: 37.5 hours per week @ $15 per hour | $ 29,250 |
| Benefits for F/T CHW | 21% of salary | $6,143 |
| Prescription gap coverage for RR patient age 60+ | 100 patients @ $80/month for 1.5 months each | $12,000 |
| **TOTAL** | | **$ 47,393** |
| Less Expected Remaining 2020 Grant Funds as of 10/31/21 | | $ 19,000 |
| **Grant Request** | | **$ 28,393** |