Trinitas Regional Medical Center Foundation | RWJBarnabas HEALTH

Trinitas' Readmission Reduction Program
Community Health Worker & Prescription Gap Coverage
Report-September 2022

1. **What problem were you addressing? What solution did you propose to address it?**

Grant funds of $28,000 in 2021 supported two components of Trinitas' Readmission Reduction program – $16,000 to support the Community Health Worker (CHW) and $12,000 for Medication Gap Coverage. The problems that the grant funding helped to address include depression and isolation with seniors through at-home visits by a CHW and medication gap coverage 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. Often these patients go without medications for their chronic illness, putting them at risk for hospital readmission. With respect to the CHW, 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. The CHW visits patients at home and spends on average 2-3 hours/week for about 3 months to provide companionship and help with food shopping and meals and give reminders about medications and doctor appointments. Due to COVID, there were several times during 2021 that the CHW could not provide in-person visits and instead used FaceTime or phone calls to connect with patients.

2. **What actions did you take? What worked and didn't work toward your objectives? Please share any unanticipated benefits or barriers encountered.**

The CHW visits patients at home to provide companionship, assistance/reminders about medications and follow-up doctor appointments, helping with food shopping and meals and working with the social worker to connect patients to outside programs for sustained socialization. Assistance with doctor appointments and medication reminders helps to ensure compliance with post-discharge protocols and improve patient outcomes and lower readmissions since non-compliance with medications and doctor appointments is associated with an increased risk for readmission within 30 days of discharge. The CHW also helps 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. Another benefit is that the CHW acts as a "second set of eyes" on the patients and alerts the program's APN if they detect anything of concern. Having a CHW 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. 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. The CHW also keeps a log of each patient they have seen. They track the number of visits with the patient, the activities that were done, and what the patient's needs are.

For the medication gap component, patients who are in need of prescription assistance are identified prior to discharge and the social worker who is part to the RR team works with them to enroll in pharmaceutical assistance programs (PAP), if available and/or get free medications through our partnership with St. Joseph's Services or other available resources. The application process for PAP can be time consuming so going forward the RR team will look to the CHW to assist patients in the PAP application process.

3. **How did you measure success--both quantitative and qualitative? Please include numbers and demographics of people touched by the work.**

Community Health Worker - The CHW uses the PHQ-9, a standardized screening tool used to gauge feelings of depression to assess effectiveness of the program as well as an informal questionnaire to gauge patient needs, which are summarized below. In addition, readmission rates are tracked for patients seen by the CHW as well as for RR patients overall. During 2021 the CHW served 30 patients, with 3 (10%) readmitted –all related to COVID-19. Two were readmitted with symptomatic COVID-19 and one readmitted due to anxiety associated

with the COVID-19 infection. It should be noted that the three readmissions were not directly due to the patient's chronic illness but rather to COVID-19, which skews the readmission rate. Overall, the readmission rate for the 458 patients served by the RR program in 2021 was 5.7% with 25 patients readmitted. The 30 patients served by the CHW ranged in age from 64-93; 16 were Latinx, nine were African-American and five Caucasian. The overall PHQ-9 score for the 30 patients decreased from 29 to 25, a 14% decrease, indicating an improvement in feelings of depression and isolation. Patient information for 2022 is collected and logged at each CHW visit and will be compiled and assessed by year-end and shared with Friends. We do expect similar results to 2021. If interim results are desired, please let us know.

Patient Needs	Frequency	Percent
Companionship	16	53.5 %
Medication Assistance	8	26.6 %
Meal Assistance	3	10.0 %
Encouragement/Assurance	2	6.6 %
Assistance with errands	1	3.3 %
Total	30	100 %

Medication Gap Coverage -For the medication gap component, between November 2021 and July 2022, 72 patients between the ages of 60 and 87 received assistance with medication payments totaling $5,013, with an average of $627/month. Payments ranged from $2.74 - $200 with an average amount of $63.39/patient and a median of $60. Patients receiving medication assistance suffer from Chronic Conditions that include congestive heart failure and other coronary diseases, diabetes with other comorbidities, COPD and other respiratory ailments and hypertension with comorbidities Of the 72 patients, over 70% were either uninsured or on Charity Care, 17% were on Medicaid or Medicare and only 11% had private insurance. The table below shows patients by insurance.

Insurance	# Patients	%
Charity Care	34	47%
Uninsured	18	25%
Medicaid	10	14%
Private Insurance	8	11%
Medicare	2	3%
Total	**72**	**100%**

4. **How did partnerships/collaborations enhance or challenge the project?**

The RR program partners with several social service organizations in Elizabeth and Union County. This includes St. Joseph's Social Services in Elizabeth free medication, clothing and food for the Elizabeth residents, Community Food Bank of NJ who provide a week of healthy meals for RR participants upon discharge from the hospital, and Community Pharmacy who provide deep discounts for medications for RR patients. Also through an introduction by Friends to the Rutgers Graduate School of Social Work, a Rutgers MSW graduate student completed her field placement at Trinitas for the 2021/2022 school year. As part of her field placement, she compiled a report/research paper that included a detailed description and assessment of Trinitas Readmission Reduction Program, an analysis of the programs impact on readmission rates, as well as research and comparison of similar programs offered at other hospitals and healthcare facilities.

5. Include a budget and actual for the project during the reporting period.

The $28,000 grant that Trinitas received in 2021 was allocated as follows: $16,000 went towards the salary and benefits of a F/T CHW and $12,000 was allocated to medication gap coverage. This grant combined with $19,000 remaining from our 2020 Friends grant was projected to fund both the CHW position and medication gap coverage through November 2022. Based on actual use of funds shown below, as of end of July 2022, there is $6,987 remaining for medication gap coverage that is expected to cover medication gaps for our patients through June 2023 based on about $600/month. For the grant funds supporting the CHW, as of the end of August 2022, there was $10,560 remaining, which we expect to be expended by year-end 2022.

Medication Gap Coverage - Budget and Actual

Item	Budgeted Cost	Actual - 11/22-7/23	Remaining Grant Funds
Prescription gap coverage for RR patients age 60+	$ 12,000	$ 5,013	$ 6,987

Community Health Worker - Budget and Actual			
Budget Item	**Budgeted Cost**	**Actual - 11/22-8/25**	**Remaining Grant Funds**
Community Health Worker Salary and Benefits =37.5 hours/week @ $15 per hour= $29,250 + 21% for Benefits	$ 35,393	**$ 24,832.50**	**$ 10,560.00**

Summary of Grant Funds to Support CHW	
2021 Friends Grant for CHW	$ 16,000
Remaining 2020 Grant Funds as of 10/31/2021	$ 19,152
Total Grant funds for CHW	**$ 35,152**

6. **What conversations have you had on how to sustain the project after the grant, and do you have plans to share your results with other organizations?**

Due to the work involved with the merger of Trinitas with RWJBarnabas in combination with the hiring challenges that the healthcare industry is currently facing, we were not able to have dialogue regarding the hospital assuming the costs of CHW position. However, given the success of the CHW program in reducing readmissions, every effort will be made to include the cost of the position in the department's 2024 operating budget. As noted above, the report that the Rutgers MSW intern completed was shared internally, with Friends, with Rutgers as part of her MSW fieldwork, and can be shared to other external interested parties.

7. 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 were thrilled with our Rutgers MSW intern. We also appreciate the open dialogue and opportunity to ask questions and provide updates during the grant period. FFA 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 a full recovery at home.

8. 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!