**Date:** 8/30/2024

**Organization**: Trinitas Foundation **TIN**: 222353773, Trinitas Foundation

**Contact name, phone, email:** Christina Oztan, 908-994-8210, christina.oztan@rwjbh.org

**Amount requested**: $17,302

**Project title**: From Hospital to Home -Closing the Home Care Gap

**Summary Description (maximum 25 words):**

Eliminate identified gaps in care for seniors in Trinitas' Transitional Care program including support for healthy meals provided to patients at discharge; short-term medication assistance and equipment so patients can self-monitor their conditions at home.

**What is the problem you have identified?**

Trinitas is seeking a $17,302 grant to support our Transitional Care Program, a hospital wide program that has been operating at Trinitas since 2013 that provides at-home support to our recently discharged elderly chronically-ill patients who are at high risk for readmission, to ensure their safe recovery at home. The program serves 400-500 patients annually and targets chronically-ill patients with Hypertension, Diabetes, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Acute myocardial infarction and pneumonia, most of who are financially disadvantaged and uninsured or underinsured. Our program provides support for 1-2 months after discharge as it is during this time that patients face their greatest challenges in complying with post-discharge protocols and learning to manage their illnesses. The program addresses many socioeconomic factors including access to basic necessities such as housing, healthy food, medication, transportation and insurance. Without the proper support, this can easily lead to relapses and catastrophic events such as heart attacks and strokes.

Thanks to support from Friends Foundation for the Aging since the program was launched, the program has had tremendous success in improved patient outcomes and reduced hospital readmissions for our most vulnerable elderly patients through its care centered team that includes an Advanced Practice Nurses (APN), an outpatient social worker, a registered dietitian and a Community Health Worker. While Trinitas supports the salaries of the program's staff, there are components of the program that Trinitas is not able to fully support due to budget constraints and our status as a safety net hospital that serves a high percentage of uninsured and underinsured patients. The gaps in funding for which we are seeking support are three-fold and include the following: Note funding will support patients in the program 60 years and older.

1. Heart healthy meals provided to patients at discharge
2. Short-term medication assistance for uninsured or underinsured patients and
3. Equipment for patients to monitor their chronic-conditions at home

**What is the solution you propose to address the problem? What actions will you take?**

**Support for healthy food**

Food insecurity, particularly as it pertains to healthy food, is an issue for almost all of Trinitas' patients, but it can be life threatening for patients in our Transitional Care Program. To address the need for immediate access to healthy food, at time of discharge, Transitional Care patients are provided with 10 frozen meals prepared by the Community Food Bank of NJ in accordance with American Heart Association Guidelines and provided at a discounted rate per meal. If warranted, additional meals are provided until other community services are put in place, such as Union County Meals-on-Wheels. This is a critical component of the program as many of our patients are impoverished and/or food insecure as well as adjusting to new diets due to their chronic illness. Our staff also provides nutrition counseling and food preparation instructions

since there is a direct link between diet and successful recovery. The initiative ensures continuity of care as it specifically relates to the patient's nutritional needs, and directly contributes to their safe and healthy recuperation.

**Support for prescription medicine**
For chronically-ill elderly patients there is an immediate need for medication upon discharge from the hospital. Often patients who are under-insured or uninsured or who can't afford prescription copayments which can cost several hundred dollars a month, go without all or some of their medication upon discharge. This greatly increases their chance of being readmitted to the hospital or experiencing catastrophic events due to their illness such as a stroke or heart attack. Grant funds will cover the cost of medications for patients age 60 and over who are under/uninsured or who cannot afford their medication copayments, until they can be set-up to receive free or low-cost medications from other sources. For most patients, this will take from 1-2 months. Hospital medical staff, including nurses and doctors, are all are aware of the Transitional Care program and the medication assistance component. They contact the TC team when they become aware that a patient cannot pay for prescription medication. To ensure our patients' long-term health, our TC staff also actively guides them through the enrollment process for Medicare, Medicaid and/or pharmaceutical prescription assistance programs. These applications can be confusing and overwhelming for many patients, particularly when English is not their first language.

**At-home medical equipment**
For patients with diabetes and/or hypertension, self-monitoring is critical in managing these chronic conditions. As such, the program provides blood pressure monitors and/or blood glucose meters for patients diagnosed with hypertension and/or diabetes who are uninsured or whose insurance does not cover such equipment, so they can monitor their conditions at home. The program's APN provides hands-on step-by-step instructions, including the warning signs that warrant a call for additional assistance. In addition, as many chronic conditions are related to obesity and being overweight, scales are provided to those patients who need to monitor their weight.

Overall support for these components of the program will improve patient outcomes, reduce readmissions and reduce life changing events such as no or fewer strokes, heart attacks and diabetic events as patients will be able better comply with dietary changes, adhere to medications and be able to monitor their illness at home.

**Describe the population to be served.**
The program serves 400-500 patients annually and targets chronically-ill patients with Hypertension, Diabetes, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Acute myocardial infarction and pneumonia, most of who are financially disadvantaged and uninsured or underinsured. Grant funds will support patients in the program who are 60 years of age and older.

**Are there partners/collaborators for implementation or funding-who? Has the solution been tried by other organizations?**
Partners include 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 at discounted cost, and Community Pharmacy who provides discounts for medications for TC patient.

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

- Provide 150 elderly patients with 10 heart healthy meals upon discharge. Meals will be provided to those patients identified as food insecure or needing food support. In addition, patients will be provided with nutritional education specific to their condition and healthy food demonstrations at bi-monthly support groups.

- Provide medication assistance to approximately 75 patients age 60 and older with limited or no insurance. Typically, assistance will be provided for 1-2 months until free or low-cost medicine sources can be secured. For eligible patients, social worker will help to apply for Medicaid and/or Medicare.
- Provide blood pressure monitors to 150 patients who are 60 years and older with hypertension and train on proper use so they can monitor their condition at home.
- Provide blood glucose meters to 150 patients who are 60 years and older with diabetes so they can monitor their condition at home.
- Provide 150 patients who are 60 years and older with scales to track their weight at home. Many chronic illnesses are related to being overweight and require changes to diet in order to lose weight and improve outcomes.
- Reduce readmissions and medical events for those patients provided with medication assistance and BP monitors and/or glucose meters.
- Track 30-day readmission for all patients enrolled in the program

**Program Budget**

**TRANSITIONAL CARE PROGRAM**

**From Hospital to Home - Closing the Home Care Gap**

| Budget Item | # | Cost | 12 Month Budget Total | Funding Committed | Funding Requested |
|---|---|---|---|---|---|
| **Equipment for at-home Monitoring** | | | | | |
| Blood Pressure Monitor | 150 | $ 35.00 | $5,250 | $ 1,000 | $4,250 |
| Scales | 150 | $ 15.00 | $2,250 | $ 500 | $1,750 |
| Glucose Meter for Diabetics | 150 | $ 10.00 | $1,500 | $ 500 | $1,000 |
| Glucose Strips for 1 year | 150 | $ 14.00 | $2,100 | $ 1,000 | $1,100 |
| **TOTAL EQUIPMENT** | | | **$11,100** | **$3,000** | **$8,100** |
| **Food Support** | | | | | |
| Frozen Meals at Discharge (10 meals per patient @ $4.013/meal)) | 150 | $ 40.12 | $6,018 | $ 3,000 | $3,018 |
| Thermal Bags to keep food cold | 150 | $ 4.39 | $659 | $ 475 | $184 |
| Food for bimonthly Support Group | 6 | $ 400.00 | $2,400 | $ 2,400 | $0 |
| Shoprite Gift Cards for Food Shopping Activity | 25 | $ 25.00 | $625 | $ 625 | $0 |
| **TOTAL FOOD SUPPORT** | | | **$9,702** | **$6,500** | **$3,202** |
| **Prescription Medicine Coverage** | **75** | **$ 80.00** | **$6,000** | **$0** | **$6,000** |
| **GRAND TOTAL** | | | **$26,802** | **$9,500** | **$17,302** |

Trinitas has received a total of $9,500 in support including $3,500 from the Wawa Foundation to support nutrition education/food component of the program and $6,000 from Trinitas' Internal RFP program for the meals provided to patients at discharge and the equipment for at home monitoring.