Proposal to the Friends Foundation for the Aging
Trinitas Readmission Reduction Program
Friendly Home Visitors
2020

I. Executive Summary

The Trinitas Health Foundation respectfully requests a $35,408 grant to support the expansion of the ***Friendly Home Visitors*** component of our broader Readmission Reduction (RR) program. Readmission Reduction is a hospital wide program to reduce the 30 day readmission rate of our recently discharged elderly chronically-ill patients who are at high risk for readmission by providing at home support to ensure their safe recovery at home. ***Friendly Home Visitors*** was piloted late last year in order to combat loneliness, isolation and depression prevalent with our RR patients. The program utilizes Community Health Workers (CHW) who provide weekly at-home visits to our recently discharged elderly chronically-ill patients who are at high risk for hospital readmission to provide companionship, conversation and assistance/reminders about medications, doctor appointments, meals, etc. We currently have two part-time CHWs who each visit 6-7 patients once a week for 2-3 hours. Since starting the program in December, we already have very positive results - including one patient whose blood sugar is now under control because the CHW is food shopping with him and helping him to make appropriate food choices and another patient who would not leave the house and now participates in activities like bingo at her senior housing development - and there are more patients in need so we are looking to expand the program by hiring two more part-time CHWs who will make weekly at-home visits to participants 65+ in Union County, who are at risk of social isolation. Grant funds will enable us to cover the cost of two part-time CHWs for a year and will cover expenses including salary, travel and phone.

II. Brief Statement of Context for the Proposed Program

Serving those that are poor and vulnerable is at the heart of Trinitas' mission and the primary driver behind our hospital's programs. The *Readmission Reduction program* is an excellent example of our mission-based programming. The program is a targeted approach to addressing the holistic and medical needs of our elderly chronic disease patients when they are released from our Medical Center to ensure their long-term recovery at home. The program targets chronically-ill patients with Hypertension(29%) , Diabetes(26%), Chronic Obstructive Pulmonary Disease(19%), Congestive Heart Failure(15%), Acute myocardial infarction and pneumonia (11%), most of who are seniors and are financially disadvantaged.

Thanks to support from FFA, The *Readmission Reduction Program* has made great strides in reducing readmission rates. The program has been operating at Trinitas since 2012 and since then has served over 2,169 patients. In 2019 the program served 410 patients with a 10% readmission rate compared to 34% before the program. The program has had much success through its care centered team that includes two full-time Advanced Practice Nurses (APN), a full-time outpatient social worker and a full-time registered dietitian. The APNs provides clinical support to the patient and his/her caregivers and can write prescriptions for medicine. The outpatient social worker ensures continuity of social services and connects outpatients to community services and the bilingual outpatient dietitian provides patient education and nutritional counseling. Together the team provides comprehensive coordinated care so the patient can recuperate safely and healthfully at home.

The RR team has identified social isolation and loneliness as issues for many of the program's patients. This is of concern as social isolation and loneliness have emerged as public health issues and have been shown to be risk factors for poor aging outcome and are associated with poor health, depressed mood, decreased quality of life, increased likelihood of hospitalization or nursing home admissions and increased mortality. In addition, low-income people and ethnic minorities are more susceptible to isolation due to limited resources. This is of particular concern to Trinitas as we serve a high percentage of low-income immigrants. There are also financial implications and a recent study by AARP and Stanford University which looked at Medicare data found that a lack of social contacts among older adults is associated with an estimated $6.7 billion in additional federal spending annually.

To address these issues, Trinitas piloted ***Friendly Home Visitors*** as part of the RR program with funding from The Grotta Fund in late 2019. ***Friendly Home Visitors*** utilizes Community Health Workers (CHW) who work in coordination with our RR team to provide participants with weekly home visits to 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. CHWs 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 help with food shopping, if needed, ensuring that patients choose the proper foods for their chronic illness, and also help them to prepare meals. This in turn can help with their chronic illness such as diabetes. CHWs track # patients seen, # visits and activities and time spent with each patient as well as assist in completing two assessments at the first visit, mid–cycle and final visits that are used to evaluate the effectiveness of the program. Having CHWs visit patients shortly after discharge and for a sustained period of time – three months on average -is also very helpful because it gives the APNs a second "set of eyes" on the patients, especially 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. By visiting with patients for about three months after discharge, the CHWs provide that additional support to ensure continued medication compliance and are able to alert the APN of issues that might interfere with their continued recovery at home. In addition, CHWs will make follow-up phone calls with patients and provide additional visits throughout the year, as needed.

CHWs are trained and supervised by the APNs and work 20 hours per week with approximately 15 hours spent visiting patients and 5 hours for administrative work, tracking patient visits and making follow-up phone calls to participants. Each CHW visits 6-7 patients each week for 2-3 hours for a total of 12 visits per patient. Currently there are two Community Health Workers, one who is bilingual, who work with the Trinitas RR Team. Due to the positive response of the program and the profound positive impact it is already having on patients - including one patient whose blood sugar is now under control because the CHW is food shopping with him and helping him to make appropriate food choices and another patient who would not leave the house and now participates in activities like bingo at her senior housing development -we are seeking to add two more part time CHWs as there are more patients in need of the program

than the current two CHWs can serve. With two additional CHWs we would be able to serve a total of about 96-112 patients annually with four part-time CHWs.

III. Organizational History & Competence

Trinitas is a major center for comprehensive health services for those who live and work in central New Jersey. Operating on two major campuses, Trinitas has 554 beds, including a 120 bed long-term care center. Annually, we treat nearly 18,000 inpatients and see over 450,000 outpatient visits. Our patients largely reflect the demographics of Elizabeth a densely populated, low-income, urban immigrant city where 47% of the residents are foreign born and 75% of households do not speak English in the home. 64% of residents are Hispanic and 21% are of African-American descent. Poverty rates range from 17% for families to 45% for single parent families with young children.

At Trinitas, we are guided by our mission: We dedicate ourselves to God's healing mission. We strive to provide excellent, compassionate healthcare to the people and communities we serve, including those among us who are poor and vulnerable. As a Catholic hospital, we are dedicated to providing high quality healthcare to every person who needs us, regardless of their ability to pay. As such, we are one the state's foremost safety net hospitals and consistently manage the 2nd to 3rd largest charity care caseload in the state. As a safety net hospital we serve a very high percentage of low-income patients, many who are uninsured or underinsured and as a result we lose money on over 81% of our patients and must raise funds to continue to serve many of the underserved who come to us for healthcare services. Trinitas Health Foundation is the philanthropic arm and raises funds to provide vital financial support for the hospital's many equipment, capital, program and service needs.

With Friends Foundation for the Aging's support and commitment to our high-risk elderly patient population, Trinitas has been successful in reducing readmission rates. Our Readmission Reduction program has improved patient outcomes and reduced hospital readmissions for our most vulnerable elderly patients while improving the hospital's bottom line. Since the program began in 2012, we have provided an intensive level of assistance to over 2,000 of our elderly patients and we have made excellent headway in reducing readmission rates and improving quality of life among our most vulnerable patients. The Readmission Reduction program is not only having an incredible long-term impact on the welfare of our patients but also on Trinitas' ability to remain a sustainable hospital serving the healthcare needs of our community.

IV. Goals and Objectives

Objectives include:

- Hire and train two part time Community Health Workers who annually will serve 24-28 elderly patients each for a total of 48-56 patients for both CHWs during funded period (one year)
- CHWs will visit patients each week for 2-3 hours for a total of 12 visits, providing companionship and assistance/reminders about medications and doctor appointments and ensure meals are eaten. CHWs will also assist patients with completing two surveys at the initial and final visit and mid-cycle to assess the effectiveness of the program. CHWs will 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.

- Total patient visits for each CHW is 288 (24 patients X 12 visits) annually, for a total of approximately 576 visits for two CHWs
- Track readmission rate of patients in program

Outcomes include:

- Decreased feeling of isolation and loneliness
- Improved mood and a decrease in depression based on PHQ-9 depression assessment
- Increased participation in doing things like hobbies, playing board games, conversing, etc.
- Improved eating shown by fewer missed meals
- Improved medication adherence shown by a decrease in missed prescriptions
- Fewer doctor appointments missed
- Lower readmission rate compared to overall program readmission rate

V. Project Details, including Timeline, Methodology/Actions and Capacity to Accomplish Goals

- Upon receiving grant funds, two part-time CHWs will be hired and trained by RR staff. We expect this to take 1-2 months. Based on past experience of hiring CHWs, finding the appropriate candidates was challenging due to job requirements including preference for bilingual candidates and being comfortable with driving in Elizabeth and visiting people in their homes. As a result, the APN decided to proactively identify potential candidates and subsequently hired a former patient of the RR program so the candidate was well known by the RR team as well as being bilingual, and a resident of Elizabeth so was very familiar with the community. The second CHW was a former Certified Nursing Assistant at Trinitas. The RR team knew her well and she was chosen because she is familiar with the hospital and working with Trinitas patient population. She is not bilingual but there are enough patients who are not bilingual or are proficient in English. If awarded, we expect to use the same strategy to hire the CHWs as the program is so specialized and requires a very specific type of candidate.

- Ongoing – Recruitment of patients. Participants will be elderly patients from Trinitas' RR program who have been identified as at risk for social isolation and loneliness. Patients are being actively recruited for the program. Although initially there were challenges in recruiting patients for the program, the RR team worked to alleviate patient and family concerns and now the program has more patients needing and interested in the service than we can serve at this time.

- Upon being trained each CHW will be assigned 6-7 patients who they will visit each week for 2-3 hours for a total of 12 visits. They will each serve a total of 4 cohorts of 6-7 patients annually for a total of 24-28 patients served annually by each CHW for a total 48-56 patients served by both CHWs.

- Activities: CHWs will:

    - Provide companionship through conversing, playing cards and games, doing puzzles and hobbies and reading. This can include identifying interests and

hobbies and working with the social worker to connect patients to outside programs for sustained socialization.

- Provide assistance/reminders about medications and ensure follow-up doctor appointments are attended and made. This will help ensure compliance with post-discharge protocol for medications and doctor appointments and improve patient outcomes and lower readmissions.
- Help monitor chronic illness by assisting with taking blood pressure and blood glucose, if applicable, and alerting APNs if have abnormal reading.
- Ensure meals are eaten, help with food shopping, ensuring that patients choose the proper foods for their chronic illness, and help prepare meals.
- Help participants complete two assessments at the first visit, mid cycle and final visit in order to evaluate the effectiveness of the program. The assessments are included below. The first, Survey 1, will gauge loneliness, feelings of sadness and how often meals, appointments and medications are missed. The program also utilizes the PHQ-9 Patient Depression below, a tool used to gauge feelings of depression in patients.
- Make follow-up phone calls with patients and additional visits throughout the year, as needed.

VI. Budget

Item	Description	Total Cost
Community Health Workers Salary	2 part-time CHWs: 20 hours per week @ $15 per hour=2 x $15/hr. x 20hrs/wk. x 52 wks. = $31,200	$31,200
Mileage (for patient visits)	Mileage at $.56 per mile: 2 x $.56/mile x 50 miles/wk. x 52 wks.=$2,912	$2,912
Phone (for contacting patients and RR team)	$54/mo.: 2 x $54/mo. x 12 mos. = $1,296	$1,296
TOTAL		**$35,408**

VII. Sustainability

As a safety-net hospital, it is imperative that we explore and implement innovative ways to reduce costs and reduce our losses due to low reimbursement rates as we serve a high percentage of uninsured and underinsured elderly patients. Our Readmission Reduction Program is one of our innovative programs that exemplify our commitment to innovation and sustainability while serving our most high-risk patients. Operating since 2012, the RR program is one of Trinitas signature programs. It has been very successful in reducing readmission rates and is not only having an incredible long-term impact on the welfare of our patients but also on Trinitas' ability to remain a sustainable hospital serving the healthcare needs of our community. The program has full support from the hospital's leadership as evidenced by institutional and grant funding over seven years. Some components of the program such as the social worker and dietician were initially funded by FFA but are now supported by Trinitas as the FFA grants allowed us to demonstrate organizational savings through lower readmission rates which has enabled Trinitas to support the positions full-time since being funded by FFA.

For this particular component of RR program, funding from FFA will provide us with time to test this important initiative and analyze results. While the initial pilot test results are positive it is

too early to determine if the program should be continued. If continued, the program most likely would have to be grant funded unless the hospital can justify savings due to the program's decrease in readmission rate or other cost savings. The Trinitas Health Foundation is confident that if successful the hospital will continue the program as it has done before and the Foundation is always actively researching and identifying funders to support programs and hospital needs that cannot be supported through operations.

VIII. Measurements of Success

CHWs will help participants complete Survey 1 and PHQ Questionnaire, both attached, at the first, middle and last visit to assess the effectiveness of the program. Success will be measured by improvements in the survey responses over a period of approximately 12 visits by the CHWs. Based on results of 2 assessments after 12 visits and tracking readmission rate, success will be measured by the following:

- Decrease in feeling of loneliness and isolation
- Improved mood and a decrease in depression based on PHQ-9 depression assessment
- Improvement in quality of life shown through participation in doing activities such as hobbies, games, cards, preparing meals, etc.
- Improved medication adherence
- Fewer missed doctor appointments
- Fewer missed meals
- Lower readmission rate compared to overall program rate

IX. Possibilities and methodology for replication or reporting results to the wider public

Our Readmission Reduction program uses an innovative, integrated and collaborative approach to address the issue of chronically ill, impoverished seniors in our community, and our results have been outstanding despite the many obstacles we face. Our collaborations and community partners have allowed us to leverage our resources, an essential key to success due to the budgetary constraints we face as a safety net hospital. Together, we have established a model program that can be replicated by other urban hospitals that also serve a primarily low-income, elderly underserved population. Results from Friendly Home Visitors component of the RR program will be shared with hospital leadership and interested outside entities.

X. Statement of Ways in Which the Proposal Addresses the Values of the Friends Foundation

The Readmission Reduction Program addresses the Friends Foundation for the Aging's values on a number of important levels. Both organizations place a high value on upholding respect for the individual and the dignity of every person's life. The program targets chronic disease adults, most of whom are seniors and financially disadvantaged and addresses many socioeconomic needs upon discharge from the hospital. The program works to ensure a patient's safe, long-term recovery at home by providing support to ensure access to basic necessities such as housing, food, transportation and insurance.

Our service to Elizabeth, a true melting pot and immigrant city, speaks to your interest in serving diverse populations. As noted, as a safety-net hospital we serve a high percentage of low-income and under or uninsured patients. Our patients reflect the diversity of Elizabeth, a low-income urban immigrant city where 47% of the residents are foreign born and 75% of households do not speak English in the home. With a population of over 129,000, 64% of residents are Hispanic and 21% are African-American.

With respect to leveraging resources, since Trinitas cares for so many socioeconomically challenged patients, leadership values efficient management of resources and the use of

innovative strategies as a means to counter low levels of reimbursement. One of the most important ways we have leveraged resources is through the support of the many individuals, foundations and corporations that support our work. We have 100% financial participation from our board members and 30% (850) of employees are donors! 100% of Trinitas' Executive Leadership donates to Trinitas, as does 100% of our Leadership Council, which consists of managers, directors and vice-presidents.

Thank you for your consideration!

Trinitas Readmission Reduction Program
Friendly Home Visitors
Survey 1

Survey completed at first visit, mid-cycle and final visit. Respond to each question using the following scale: 1. Never 2. Rarely 3. Sometimes 4. Always

1. How often do you have people visiting you in a week?
2. How often do you feel alone?
3. How often do you feel that there are people you can talk to?
4. How often do you have little interest or pleasure in doing things?
5. How often do you feel sad or depressed
6. How often do you forget to take medications?
7. How often do you miss doctor appointments?
8. How often do you miss meals?

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005