Cleveland and Fort Lauderdale AgeWell Pilots Formative Evaluation Report: January 1, 2017-February 28, 2018

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EXECUTIVE SUMMARY

INTRODUCTION

The purpose of this evaluation is to provide information helpful for the continuous quality improvement of AgeWell, a program designed to drive down health care costs for older adults. The plan in the initial proposal was to conduct formative evaluations in Cleveland and Pittsburgh. Insurmountable legal issues resulted in the Pittsburgh site not moving past the exploratory phase. Instead, retrospective evaluation of the Fort Lauderdale site was conducted to provide a site comparison for Cleveland.

EVALUATION METHODOLOGY AND IMPLEMENTATION

Sources of information used in this evaluation included the following:

- Literature reviews related to key components of the AgeWell intervention
- Semi-structured interviews with key stakeholders at Cleveland and Fort Lauderdale
- Observation of the AgeWell Pre-Service Training in Cleveland
- Semi-structured interviews with AgeWells regarding training
- Focus group with AgeWells in Cleveland regarding their experiences serving patients
- Semi-structured interviews with key Cleveland staff regarding implementation
- Observation of weekly meetings between AgeWells and supervisor in Cleveland
- Observation of key implementation events in Cleveland such as first face-to-face meeting between AgeWell Global, Fairhill Partners, and MetroHealth Systems.
- Observation of phone meetings between Fairhill Partners, MetroHealth, and AgeWell Global staff to discuss implementation activities.
- Document review of workflows, job descriptions, and timeline documents

EVIDENCE SUPPORTING THE THEORY OF AGEWELL INTERVENTION

AgeWell Global has evolved two service models for AgeWell:

1. A community-based model designed to improve well-being and avert preventable hospitalizations and ER visits among chronically ill older adults, the highest utilizers of medical services
2. A post-hospital discharge program model (HDPM) for older adults with chronic medical problems; designed to improve well-being and prevent hospital readmissions during and beyond a 30-day and 90-day post-discharge period.

The AgeWell intervention consists of two primary components:

AgeWells. AgeWells make home visits and regular telephone calls to help individuals in the community or post-discharge to combat loneliness and reduce isolation and also identify occurring or recurring health problems.

AgeWell's focus on companionship and social support aligns well with the large body of research indicating that social relationships and the support they provide are associated with reduction in isolation and loneliness, and better health and well-being outcomes. Research is less clear, however, on whether social support interventions can create meaningful relationships that lead to positive impacts. In general, it appears that bundled care transition programs with multiple intervention components are most likely to be effective. One particular model of transition care widely cited as successful in reducing hospital readmissions is the Care Transition Intervention (CTI) model, which has been evaluated and found to be effective in reducing hospital readmissions across different patient populations in multiple settings. CTI focuses on empowering the patient to successfully self-manage after hospital discharge by providing the patient with tools, care coordination, and patient education. The important factors that the CTI team have identified for effective implementation align with AgeWell practice in some ways but are different and sometimes lacking in others.

20/20 Health Screening Tool. The 20/20 Health Screening Tool was initially used in the community-based model and consisted of 20 observations and 20 questions designed to identify evolving health and social problems. Depending on the responses, algorithms may trigger referral recommendations to the clinical coordinators. The 20/20 was adapted for the HDPM to address 11 specific diagnoses that are common causes of hospital readmission among older adults. AgeWells complete the 20/20 interview with their patients, using a smartphone during home visits. The clinical coordinators provide appropriate follow-up with clients when referral recommendations are received.

DESCRIPTION OF CLEVELAND AND FORT LAUDERDALE IMPLEMENTATIONS

Exploration is the period between initially hearing about AgeWell and making a commitment to move forward. The intuitive appeal of AgeWell was integral to uptake at both sites. Due to timing of the implementations, with Fort Lauderdale implemented several months ahead of Cleveland, much of program planning in Cleveland was driven by decisions that were made in Fort Lauderdale. The diagnoses selected to be targeted by the program (initially nine, subsequently expanded to 11) to increase patient enrollment numbers) were based on Fort Lauderdale data. The AgeWell charter created in Fort Lauderdale in collaboration with program partners at Holy Cross Hospital and Trinity Health, was adapted for use in Cleveland.

Pre-implementation is the phase from when the commitment is made until the first patients are recruited. In a hospital discharge model, the hospital is a key partner and needs to be engaged

as early as possible in the planning process with a program champion. Pre-implementation includes recruiting and training staff, developing processes, and ironing out legal and other agreements. Overall, the evaluators felt that the material presented during the Cleveland training placed greater emphasis on the 20/20 survey and less emphasis on relationship building than would be expected given the centrality of peer support in the theory of change underlying the AgeWell program. AgeWells were positioned to be an early warning system for health providers as a result of the training but seemed less well positioned to enhance social support. The evaluators also had concerns that the training did not cover medication management/monitoring and the AgeWells' role in these activities in sufficient depth. In general, AgeWell was strong in the exploration phase with an intuitively appealing program, but met with challenges in the pre-implementation phase. This was in large part because the hospital discharge program model was new to AgeWell, and there was lack of clarity on how it would work. Despite having highly skilled AgeWell staff to provide program support the many details to be handled and processes to put in place were challenging.

The Implementation phase begins when the first patients are enrolled. AgeWell managed many challenges during implementation with characteristic flexibility and agility. However, key differences emerged between sites during the implementation phase of the program. These differences may be due in part to the different implementation support approaches enacted by AgeWell. Implementation in Florida was managed primarily by AgeWell employees. The Site Coordinator and Case Manager were AgeWell employees given space to work within Holy Cross Hospital. In Cleveland, implementation support was managed through a training and technical assistance model. Our informants suggest that the absence of AgeWell personnel onsite slowed uptake and contributed to program drift. Face-to-face contact is important for resolving problems and keeping things moving forward. The fact that AgeWell was new to the hospital discharge program model and did not have anyone on the ground made implementation in Cleveland challenging.

IMPLEMENTATION SUPPORT SYSTEM

Host support can be provided through such things as leadership, skills, motivation and buy-in and the capacity of the host can be developed through such things as training, technical assistance, and coaching. In the case of the AgeWell HDPM, Holy Cross hospital served as the host for the initial development of the hospital model in Fort Lauderdale, while Fairhill Partners and MetroHealth Hospital served as co-hosts in Cleveland. Neither site appeared to have a dedicated appraisal of the hospital or health system where AgeWell was being implemented and this absence was mentioned by our informants as a valuable piece that had to be abandoned due to a short planning and implementation window. AgeWell invested significant resources with their host organizations through guidance in planning, training, and providing technical assistance from AgeWell consultants to get the programs off the ground. One strategy to ensure that the host has

what is needed is to provide it. The extent to which this strategy is feasible, as AgeWell grows into new sites, is an important consideration for the AgeWell program.

AGEWELLS COMPONENT OF MODEL

AgeWells provide companionship, social support, referrals to community resources, and friendship. AgeWells work independently and they are in charge of managing all of their clients, scheduling their own visits, and determining whether a client is a good match for them. Initial enrollment went slowly in both sites. In Cleveland, particular concern was given to safety, with the clinical coordinator screening out patients that represented potentially problematic home situations that could jeopardize the safety of the AgeWells. By contrast AgeWells in Fort Lauderdale were described as "fearless." Other areas of difference also included the practice of community referrals. In Fort Lauderdale, extensive continuing education was provided to AgeWells regarding community resources. In Cleveland, social service referrals were provided primarily by the site coordinator.

RECOMMENDATIONS

Recommendation #1: Assess organizational readiness to facilitate uptake. AgeWell should identify and assess critical components of organizational readiness to facilitate uptake of the intervention in future iterations. This should include as assessment of motivation, general capacities (knowledge, skills, and abilities associated with the adoption of any innovation), and innovation specific capacities (knowledge, skills, and abilities related to the particular program or service being adopted).

Recommendation #2: Determine how AgeWell HDPM fits with the existing care transitions/readmission activities. As AgeWell attempts to find their niche, they are unlikely to find health care systems waiting for a new stand-alone intervention to put in place. The best care transitions programs use multiple approaches, and AgeWell could be an effective add-on approach. Standardizing a process for developing workflows and assessing how AgeWell fits with existing programs will allow AgeWell to effectively find the areas needing modifications and the areas where AgeWell brings in strengths. In particular, AgeWell presents an opportunity to address the particular challenges of patients with low social support.

Recommendation #3: *Strengthen and systematize peer companionship.* We recommend several areas where the AgeWell role can be better defined to ensure program success, such as developing a systematic protocol for the peer role, and strengthening the peer role with additional follow-up and ongoing education.

Recommendation #4: Refine and validate the 20/20 technology. In the discharge model pilots, the care coordinators were frustrated by insensitivity of the 20/20 protocol to patient circumstances, emphasizing that the 20/20 should be developed to accommodate specific patient baselines.

Without a more rigorous examination with a control group, it is hard to say with certainty that the identification of red flags is having any impact on reducing hospital readmissions. A more integrative system would streamline some of the key data collection and data management efforts. A strategy for including a user-friendly data collection effort for medication management and adding the ability to reschedule appointments is suggested.

It should be noted that the AgeWell Global staff is highly entrepreneurial, motivated, dedicated, and skilled. They have learned a great deal in the last 16 months, along with this evaluation team. As part of project close-out, a de-brief strategy to capture what has been learned and to consider what could be been done differently will help them chart a course for their future initiatives.

INTRODUCTION

The purpose of this evaluation is to provide information helpful for the continuous quality improvement of AgeWell, a program designed to improve well-being, promote health and by extension, decrease health care costs for older adults. The AgeWell peer-to-peer care model was initially designed to improve well-being and promote health outcomes among older adults in South Africa. AgeWell does this by employing able older adults (AgeWells) to visit less able older adults in their homes. The purpose of these visits is to reduce isolation and loneliness, identify evolving social and health problems, and link seniors to appropriate primary care providers and social services. Health care costs are reduced by AgeWell through decreasing preventable emergency room visits, hospital admissions, and readmissions. The model combines best practices from several care coordination models: employing able older people as companions; providing social engagement through home visits; and deploying a mobile health screening tool and related referral algorithms to identify and address evolving health and social problems before they escalate.

This formative evaluation utilized an Empowerment Evaluation approach (Wandersman et al., 2003). This approach uses training and technical assistance to support the development of evaluation capacity in the participating settings. Ultimately, the aim of an empowerment evaluation is to mainstream evaluation activities into routine activities in service organizations. The goal is to improve implementation at other current and future sites, as well as the sites evaluated in this report.

The plan in the initial proposal was to conduct formative evaluations in Cleveland and Pittsburgh in order to learn from variability across the two sites. Although extensive efforts were made by AgeWell and the host agency in Pittsburgh, insurmountable legal issues resulted in the Pittsburgh site not moving past the exploratory phase. Instead, retrospective evaluation of the Fort Lauderdale site was conducted through interviews with stakeholders to provide a site comparison for Cleveland. Fort Lauderdale implemented AgeWell prior to Cleveland and lessons learned in Fort Lauderdale informed the roll out in Cleveland.

The goals of the initial proposed evaluation were to:

1. Customize and implement evaluation tools and technologies for AgeWell pilot sites
2. Collect data and provide formative feedback on year one activities
3. Examine the landscape of community-based health support programs and services to contextualize AgeWell efforts with existing practices
4. Convene and coordinate information sharing across multiple sites piloting AgeWell

The plan for the empowerment evaluation in our initial proposal was based on an assumption that AgeWell would benefit from the systematic planning and evaluation tools from Getting To Outcomes (GTO, Chinman et al., 2008); Planning, Implementation, Evaluation (PIE, Flaspohler et al., 2003; Wandersman et al., 2003); and the Quality Implementation Toolkit (QIT)

(Meyers et al., 2012). Very early in the evaluation we realized that AgeWell staff already had access to and made good use of planning tools in the roll out of the AgeWell intervention in Fort Lauderdale. AgeWell staff have provided the evaluators with access to their tools, including implementation work plans, training materials, staff position descriptions and sample schedules, recruitment materials, referral protocols, and web platform reference guide.

The initial evaluation plan was also based on an assumption that the AgeWell intervention was based on a clear theory of change grounded in empirical evidence. While this may hold true for the AgeWell community-based model, the post-discharge model implemented in Cleveland at MetroHealth Hospital and in Fort Lauderdale at Holy Cross Hospital is a new intervention for AgeWell Global. Review of program documentation, discussions with stakeholders, and observations of initial implementation suggest that the AgeWell hospital discharge program model (HDPM) is still undergoing significant refinement as it adjusts to needs, opportunities, and realities in the field.

Due to these observations, the goal of customizing evaluation tools (Goal 1) was abandoned. Instead evaluators have focused on providing evidence briefs on issues related to the AgeWell intervention, such as enhancing social support and reducing hospital readmissions. The ultimate goal of providing information useful to AgeWell in thinking about future implementation activities remains the same.

This formative evaluation includes literature reviews of key components of the theory of the AgeWell intervention, interviews with key stakeholders, evaluator observations from key AgeWell planning and implementation activities, and review of program materials and documents. The evaluation analyses are described in detail in the methodology section of this report.

The report is organized in the following sections:

- Section I describes the methodology used to collect and analyze the data used in the evaluation and outlines the activities of the evaluators.
- Section II provides an overview of the AgeWell intervention and evidence to support the model.
- Section III describes implementation at the Cleveland and Fort Lauderdale sites.
- Section IV discusses the implementation support system used by AgeWell Global.
- Section V discusses the AgeWell component of the AgeWell model.
- Section VI summarizes the major findings from the previous sections and makes recommendations to AgeWell Global in light of these findings

SECTION I: EVALUATION METHODOLOGY AND IMPLEMENTATION

As previously described, the evaluation team used a variety of qualitative methods. Sources of information used in this evaluation included the following:

- Literature reviews related to key components of the AgeWell intervention
- Semi-structured interviews with key stakeholders in Cleveland and Fort Lauderdale
- Observation of the Pre-Service Training for AgeWells in Cleveland
- Semi-structured interviews with AgeWell candidates in Cleveland regarding their training
- Focus group with AgeWells in Cleveland regarding their experiences serving patients
- Semi-structured interviews with key Cleveland staff regarding implementation
- Observation of weekly meetings among AgeWells and supervisors in Cleveland
- Observation of key implementation events in Cleveland such as first face-to-face meeting between AgeWell Global, Fairhill Partners, and MetroHealth Systems
- Observation of phone meetings between Fairhill Partners, MetroHealth, and AgeWell Global staff to discuss implementation activities
- Document review of workflows, job descriptions, and timeline documents

A timeline of major activities is included in Appendix A.

SEMI-STRUCTURED INTERVIEWS WITH KEY STAKEHOLDERS IN CLEVELAND AND FORT LAUDERDALE

Stakeholders were interviewed using semi-structured protocols designed to identify strengths and weaknesses of each phase of program roll-out. These interview protocols can be found in Appendices B and C. Eight interviews were conducted between August and October 2017 in Cleveland and 11 interviews were conducted between November 2017 and February 2018 in Fort Lauderdale. These telephone interviews lasted between 60 and 90 minutes.

SEMI-STRUCTURED INTERVIEWS WITH CLEVELAND AGEWELLS REGARDING TRAINING

On the final day after completing training, AgeWell candidates (AgeWells) sat down with evaluation staff to provide feedback on the training. All AgeWells who completed the training participated in the interview (N = 15). Each participant was informed about his or her rights as a research subject, provided information about Miami University's research compliance and signed consent forms. It should be noted, that not all AgeWell candidates who completed the training and participated in these interviews were accepted as AgeWells.

The interviewer asked AgeWell candidates three questions that focused on the AgeWell training: What did he or she like, what did he or she dislike, what about the training could be done differently? Another group of questions focused on the process of deciding to become an AgeWell: How did they hear about the program, why did they want to become an AgeWell? Finally, AgeWell candidates were given an opportunity to provide any additional comments or concerns.

Focus Group with AgeWells in Cleveland

Two members of the evaluation team attended a regular weekly AgeWell meeting and facilitated a discussion about their experience as AgeWells after all had begun serving at least one patient. Informed consent protocols were provided; this group was audio-taped but not transcribed. See Appendix D for focus group protocol.

Semi-Structured Interviews with Key Cleveland Staff Regarding Implementation

Care coordinators at MetroHealth, the AgeWell tasked to help with patient recruitment in the hospital ("Super AgeWell"), and the site coordinator at Fairhill Partners were interviewed regarding their experiences with serving patients. Separate protocols were used for the site coordinator at Fairhill Partners and the MetroHealth Care Coordinator because they had access to different information (see Appendices E and F, respectively). A subset of the AgeWell supervisor questions were asked of the "Super AgeWell." Interviews lasted between 60 and 90 minutes.

Observation of AgeWell Training

Staff from the evaluation team were present for each day of the trainings and debriefs and took notes in vivo.

Analysis of Observation Notes and Interview Data

Observation notes from key events, AgeWell training, and meetings, and notes from the semi-structured interviews and focus group were reviewed independently by each evaluator to identify themes from each phase of implementation. Evaluators then met to discuss identified themes. Themes reaching consensus were described with supporting data and are presented in Section III organized by implementation phase.

SECTION II: THE AGEWELL INTERVENTION

AGEWELL THEORY

AgeWell Global evolved the AgeWell model from mothers2mothers (m2m), a successful education and support program for women and mothers living with HIV in South Africa. AgeWell utilizes the peer-to-peer model developed by m2m to address the needs of the aging population. The goals of the AgeWell intervention are to reduce loneliness and isolation, improve well-being, and reduce health care costs. AgeWell was first piloted in two communities in Cape Town, South Africa in 2014. The initial pilot increased well-being scores among participants by 50% within the first month of service and reduced signs of depression by 95% in one of the communities.

AgeWell Global has partnered with local community organizations to pilot the program in South Africa, Ireland, and the U.S. (New York, Fort Lauderdale, and Cleveland). AgeWell Global has evolved two service models for AgeWell:

1. A community-based model designed to improve well-being and avert preventable hospitalizations and ER visits among chronically ill older adults, the highest utilizers of medical services
2. A post-hospital discharge or transitional care program model (HDPM) for older adults with chronic medical problems; designed to improve well-being and prevent hospital readmissions during and beyond the 30- and 90-day post-discharge period

The AgeWell intervention consists of two primary components:

AgeWells. There is a growing concern that there will not be enough workers to provide long-term services and supports to the world's rapidly aging population. Employment of able, older individuals could help increase the supply of workers. Isolation and loneliness can even be an issue for those who are older and healthy. The AgeWell Global model provides meaningful experiences to individuals who choose to be AgeWells. AgeWells make home visits to help individuals in the community or post-hospital discharge to reduce loneliness and isolation and are also there to identify any occurring or re-occurring health problems. For instance, medication management issues can lead to an increase in hospital readmission or emergency room visits. At the visit, an AgeWell tracks the patient's care needs using a smart phone based assessment tool developed for chronic health problems and targeted discharge diagnoses. Before entering the field, AgeWells receive training on the AgeWell model (see Section V for more details on the training). AgeWells are not clinicians, they are supported by clinical professionals who receive referral recommendations generated by algorithms linked to responses to questions and observations made during home visits.

20/20 Health Screening Tool. The 20/20 Health Screening Tool was initially used in the community-based model and consisted of 20 observations and 20 questions designed to identify

evolving health and social problems. Depending on the responses, algorithms may trigger referral recommendations to clinical coordinators. The 20/20 was adapted for the HDPM to address 11 specific diagnoses that are common causes of hospital readmission among older adults. AgeWells complete the 20/20 interview with their patients, using a smartphone during home visits. Clinical coordinators provide appropriate follow-up with clients when red-flag referrals are received.

Through the two components, the AgeWell model "task shifts" relational aspects of health care interactions to peer paraprofessionals with the expectation that support through peers may serve to assure adequate uptake of medical advice while serving to reduce social isolation and bolster quality of life. The home visits also provide the opportunity to observe any situations in the home that could benefit from referrals to additional service programs such as home repair and home-delivered meals.

AgeWell's Patient Care Plan includes four pillars which are implemented by the AgeWells using the 20/20 Health Screening Tool:

Red-Flag Alerts. The AgeWells are given basic training on targeted health conditions. The 20/20 Health Screening Tool is used to collect observations and responses to questions related to risks that put the client/patient at risk for hospital admission or readmission. The 20/20 algorithm uses this data to drive referrals for medical follow-up.

Medication Management. On visits with patients, AgeWells make sure that each patient is aware of how to take their medication, has an adequate supply, and has access to refills. If problems with medication management are noted, actions through care coordinators are initiated to address these problems.

Linkages to Care. AgeWells ensure follow-up appointments are made and communication between care providers is completed, and facilitate transportation, if needed.

Patients Situation at Home. AgeWells make sure patients have food and electricity and that they are living in a safe environment.

EVIDENCE SUPPORTING THE THEORY OF AGEWELL INTERVENTION

Literature reviews were conducted related to various components of AgeWell in order to inform decisions on the evolving AgeWell model.

Social support interventions. AgeWell's focus on companionship and social support aligns well with the large body of research indicating that social relationships and the support they provide are associated with reductions in loneliness and isolation and better health and well-being outcomes (DiMatteo, 2004; Holt-Lunstad, Smith, & Layton, 2010; Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015; Reblin & Uchino, 2008; Seeman, Lusignolo, Albert, & Berkman, 2001; Tomako, Thompson, & Palacios, 2006). Research is less clear, however, on whether social

support interventions—particularly one-to-one interventions—can create meaningful relationships that lead to positive impacts mirroring those seen from social support occurring in natural social structures (Cattan, White, Bond, & Learmouth, 2005; Masi, Chen, Hawkley, & Cacioppo, 2011).

The perception that a social contact is "support" comes from an individual's interpretation of the social relationship, his/her behavior within the relationship, and his/her expectations of the relationship. Thus, when planning social support as an intervention, it is important to truly create social support. This requires giving sufficient attention to creating a context that is hospitable for the formation of the kind of relationships that can come to be viewed as meaningful and supportive. Several general factors to consider include: the setting, the kinds of information about the people involved to make most salient to one another, the kinds of interactions that will be most conducive to development of a supportive relationship, and how to customize the intervention to each participant's needs. It is also important to consider that in the early stages of relationship development, attraction and positive affect are improved when both parties perceive similarity, equity in exchanges, and reciprocal disclosure of personal information. In one-to-one home visiting interventions, factors that are important for relationship development include the recipient's perception of the helper's motives and his feelings about himself (e.g., feeling indebted, feeling a threat to autonomy) are important. The recipient will likely not view the intervention as supportive if he perceives the helper to be motivated by ulterior motives or to be acting involuntarily. In addition, the recipient must feel the offer of help does not imply something negative about his competence or constrain his freedom of action or decision making.

Peer coaching interventions. Peer coaching aims to support and sustain changes in cognition, emotion, and health behavior through information sharing (Parker, Wasserman, Kram, & Hall, 2015) and from some of the studies reviewed, attributes of an ideal peer coaching program were identified. A key attribute of an ideal peer coaching relationship is one where the peer coach has a similar experience of what the patient is going through and also has the competence to boost the patient's motivation and eagerness to achieve the targeted health outcomes (Joseph, Griffin, Hall, & Sullivan, 2001). Patients' access to talking to someone who they assume has gone through what they are experiencing strengthens connections and builds trust in the peer coaching relationship.

Another feature required for successful peer coaching is relationship building. For example, the effectiveness of a peer coaching relationship depends largely on the parties' ability to have a high quality (productive) relationship; and their capability to make available the time required to build one (Parker, Kram, & Hall, 2012; Parker et al., 2015). This becomes challenging as patients and peer coaches may have differing interests, aims, and personalities; hence the complexity of building and sustaining relationships may be a limiting factor in successful peer coaching interventions (Parker et al., 2012).

Information sharing is also an important feature of ideal peer coaching. Peer coaches who have been trained on ways of improving self-management of particular chronic disease(s) are

required to be effective communicators in order to help patients stay informed (Joseph et al., 2001; Tang, Ayala, Cherrington, & Rana, 2011). Furthermore, empathy and respectfulness (Dorgo, Robinson & Bader, 2009) are also ideal features of peer coaches. These qualities enable trained peer coaches to provide a listening ear when patients are frustrated and need a medium to vent, help them stay compliant with care plans, and help those who slip to regain compliance (Joseph et al., 2001).

Interventions to reduce hospital readmissions. One of the critical points in reducing hospital readmissions is at the point of discharge from the hospital setting when care transitions to home or a rehab facility. Despite concerns about the quality of evidence, many researchers have attempted to identify characteristics of care transition interventions that may be more likely to succeed in reducing hospital readmissions. In general, it appears that bundled care transition programs with multiple intervention components are most likely to be effective (Albert, 2016; Dharmarajan, 2016; Hansen, Young, Hinami, Leung, & Williams, 2011; Laugaland, Aase, & Barach, 2011; Leppin et al., 2014; Mansah, Fernandez, Griffiths, & Chang, 2009). One systematic review of articles looking at strategies to reduce hospital readmissions suggested that while a single intervention component in isolation may not achieve results, with each additional intervention component, readmission rates decrease (Dharmarajan, 2016). In addition, a meta-analysis examining interventions aimed at reducing early hospital readmissions indicated that interventions with many components were 1.4 times more effective than other interventions (Leppin et al., 2014).

The Care Transition Intervention (CTI) model (Laugaland et al., 2011; Coleman et al., 2004) is widely regarded as successful in reducing hospital readmissions. This model stands out from others because, unlike other models which typically have been tested in single-site studies, CTI has been evaluated and found to be effective in reducing hospital readmissions across different patient populations in multiple settings, including many types of hospitals and care systems (Rennke et al., 2013).

In brief, CTI focuses on empowering the patient to successfully self-manage after hospital discharge by providing the patient tools, care coordination, and education by a medical professional trained as a transition coach (Coleman et al., 2004). A key focus of this intervention is the active participation of older adults and their caregivers in the transition process and management of their ongoing health needs. Thus, a Personal Health Record is maintained and shared with medical professionals by the patient. This record also includes a space for the patient to write questions and concerns in preparation for the next encounter with a medical professional as well as a list of "red flags"—signs and symptoms to self-monitor relevant to the patient's diagnosis. These features put the responsibility and control of communicating with practitioners across health care settings and of monitoring and responding to signs and symptoms in the hands of the patient, with assistance from family caregivers. The structure of the transition coaching component of the model also encourages patient empowerment. The transition coach is trained to act as a facilitator of self-care rather than a treatment provider. The transition coach meets the

patient in the hospital, follows up within several days to assist with medication reconciliation, and then follows up with a home visit and several more telephone calls over the period of about a month. The transition coach assists patients to set goals, to be better able to communicate their care needs with practitioners at appointments, and to understand their personal red flags and how to respond.

Although not always identified explicitly by researchers as a component of effective transition interventions, coaching and social support may play a role in the success of the CTI. One study examining qualitative responses to the CTI intervention found that patients reported enhanced self-management skills, feeling more comfortable and safe during the transition, and that the transition coach cared and was paying attention to them (Parry, Kramer, & Coleman, 2006). Patients reported specifically that the face-to-face contact involved in the model was important in the development of rapport with the transition coach. The authors of this study suggested that the perception of the coach/patient relationship as caring might enhance engagement of the patients in the self-management aspects of the intervention and the effectiveness of the model.

Beyond CTI, smaller scale studies have looked at capturing the positive effects of these relational aspects of transition coaching using peers rather than health professionals as coaches during the hospital-to-home transition, with mixed results. A 2017 review including sixty-five studies examining how peer support influences health behaviors related to disease management found many studies reported positive impacts on at least some health behaviors (e.g., knowledge, health status, utilization of services, mental health; Fisher et al., 2017). For studies that did not find any significant results, lack of acceptability of the intervention was a problem. This included issues such as concerns for confidentiality, already having peer support elsewhere, frequency of contact (less than bimonthly, contact between meetings), and content of contact (discussion of topic versus exchange related to individual goals). Other individual studies of peer support and management of disease following hospital discharge (including heart failure, stroke, diabetes, severe mental illness, and chronic spinal cord injury) have reported some positive outcomes of peer support related to improved self-management, feasibility and acceptability of the intervention to patients, and quality of life; however none of these studies found significant reductions in hospital readmissions (Houlihan et al., 2017; Kidd et al., 2016; Riegel & Carlson, 2004; Sadler, Sarre, Tinker, Bhalia, & McKevitt, 2016; Smith et al., 2011). It appears that there may be positive impacts of using peer coaches, but the effectiveness of the use of peer coaches to reduce hospital readmission has yet to be established.

In summary, the evidence-base in the literature often supports the importance of a care transition intervention. Peer coaching is also established as an important program intervention. Table 1 provides a summary of the important factors that the CTI team has identified for effective implementation, along with CTI Practices, and a comparison to AgeWell practices. For each of the factors, AgeWell practice aligns in some ways, but differs and is sometimes lacking in others. This result is not surprising given the strong, established record of the CTI, the early status of the two pilots under study, and the different approaches to the qualifications of AgeWells and CTI coaches.

Table 1. Strategies from Care Transitions Intervention Implementation and AgeWell

CTI Factors	CTI Practices	AgeWell
Model Fidelity, i.e., essential practices and roles	● Home visit is essential ● Coaches don't have competing roles, i.e., performing assessment ● Practice w/colleagues, shadow home visits	● Home visit by AgeWells is primary component ● Role is both 20/20 assessment and supportive visit ● Visit monitoring in Fort Lauderdale, AgeWells not observed in Cleveland
Selection of Coaches and Reinforcement of Roles	● Required training and ongoing learning also includes strategies for implementing in their home organizations ● Ongoing learning provides a peer-support network ● Patient-centered focus without controlling agenda or performing tasks ● Professional nurse, social worker or related field. No layperson coaches	● Required training developed; ongoing learning ad hoc as needed ● Agenda always includes 20/20 assessment ● Laypersons specifically instructed not to provide any clinical advice ● All older adults but not necessarily peers ● Weekly meetings provide ongoing peer support
Model Execution	● Adopting organization defines workflows from admission through 30-day end ● Adopting organization defines goals and approach to targeting ● Describes realistic timelines ● Ensures intervention is aligned with mission and values ● Adopting organization convenes ongoing meetings to include all relevant stakeholders ● Meetings provide opportunity to solve operational issues, overcome barriers, celebrate achieved goals	● Charter for Holy Cross designed workflows with engagement from Holy Cross, Trinity staff; key program staff at Fairhill Partners and MetroHealth aligned Fort Lauderdale workflows to Cleveland implementation ● Goals and targeting (chosen diagnoses) shared responsibility between AgeWell and hospitals ● Intervention aligned with Fairhill Partners, MetroHealth, and Trinity missions. ● Timelines driven by grant funding cycles ● AgeWell staff convened ongoing meetings ● In Cleveland meetings not always attended by staff needed to solve issues
Support to sustain the model	● Adopting organization defines criteria to sustain or expand the intervention ● Adopting organization strategies for communication of results ● Adopting organization plans for recruitment and training of additional coaches ● Adopting organization continually refines the business case for program continuation	● Grant funding determines intervention end ● RWJ evaluation allows external evaluators to communicate results ● AgeWell Monitoring and Evaluation team collects data; shared results in Fort Lauderdale but not planned in Cleveland ● Program continuation not currently planned in Cleveland or Fort Lauderdale ● Business case not yet developed

SECTION III: DESCRIPTION OF FORT LAUDERDALE AND CLEVELAND IMPLEMENTATION

This section describes and contrasts the Fort Lauderdale and Cleveland sites across the phases observed in the evaluation: exploration, pre-implementation, and implementation. The summary is based on our observations, interviews, and meetings with key stakeholders. Exploration is the period between initially hearing about AgeWell and making a commitment to move forward. Pre-implementation is the phase from when the commitment is made until the first patients are recruited. The Implementation phase began when the first patients were enrolled.

EXPLORATION PHASE

Fort Lauderdale. The Fort Lauderdale site started with AgeWell Global applying for "innovation funding" from Trinity Health (Trinity). Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation. It serves people and communities in 22 states from coast to coast with 93 hospitals, and 109 continuing care locations. Trinity has been funding innovation through a grant program for four years with the goal of creating an innovation culture within their health care system. AgeWell applied to the first round of funding that was open to grantees outside of the Trinity Health system. This was a focused call on reducing readmissions for Dual (Medicare, Medicaid) Eligible patients. AgeWell was one of 67 respondents to the call. The innovation team invited half of the proposals to a "shark tank session." AgeWell pitched the business plan to the innovation team using a combination of emotional and business arguments. The project design was appealing to the innovation team for many reasons, particularly the alignment of using able-bodied seniors as companions with the Catholic mission of Trinity. AgeWell was one of five projects funded (four external and one internal) in this innovation cycle.

Trinity identified Holy Cross Hospital (Holy Cross) as the target location for the pilot based on the higher proportion of readmissions at this site. Holy Cross is a 559-bed, acute-care, specialty referral facility. Holy Cross's involvement in the exploration phase was top down. Holy Cross was chosen as the AgeWell site by decision-makers at Trinity, and, thus, Holy Cross was charged with hosting the HDMP without full awareness of the expectations involved. They were also concurrently committed to a similarly focused pilot project from AmeriCorps. When AgeWell arrived at Holy Cross to begin work they received little fanfare, thus they concentrated on building relationships for an effective working team to implement the program. The AgeWell team was unable to complete a "landscape analysis"—an important AgeWell component for entry into new settings. There was, however, a shared commitment between Holy Cross and Trinity Health underlying the program and champions at Holy Cross to assist in implementation.

As part of the process of planning with Holy Cross, AgeWell drafted a Charter (a project plan that included mission, budget, and key metrics to track milestones and deliverables quarter

by quarter). The Charter included a comprehensive plan for implementation developed by AgeWell and the Innovation Team prior to commencing pre-implementation.

Cleveland. Adoption of AgeWell in Cleveland was negotiated among AgeWell, Fairhill Partners, Medworks, and the Cleveland Foundation. Fairhill Partners is a non-profit, community-based organization focused on lifelong learning, intergenerational relationships, and successful aging. Medworks is a grassroots, community organization working to provide quality health care and access to permanent medical homes in Northeast Ohio. Medworks and Fairhill Partners applied to the Cleveland Foundation in 2016 for funding to support implementation of an AgeWell pilot. In the initial proposal, Medworks was the fiscal agent and Fairhill Partners was to manage operations. The CEO of Medworks, however, moved to a different position during this initial phase, and the Cleveland Foundation has a policy of not funding entities with unclear leadership. Thus, Medworks bowed out and Fairhill Partners became the fiscal agent. The Cleveland Foundation decided to fund the pilot, but some decisions made in program implementation suggest the budget posed challenges as program needs and expectations became better defined.

The goal of the Cleveland pilot is to reduce post-discharge hospital readmissions among Medicare fee-for-service and Medicare/Medicaid dual-eligible patients in specific neighborhoods. Fairhill Partners and Medworks negotiated with the Cleveland Foundation on which hospital to target and landed on MetroHealth based in part on the zip codes served and alignment with funding priorities. MetroHealth is a public health system serving the greater Cleveland area.

Key points from exploration phase. In both Fort Lauderdale and Cleveland, the health care provider was the last entity brought on board. The intuitive appeal of AgeWell was integral to uptake at both sites. Due to timing of the implementations, with Fort Lauderdale implemented several months ahead of Cleveland, much of program planning in Cleveland was driven by decisions that were made in Fort Lauderdale. The diagnoses selected to be targeted by the program (initially nine expanded to 11 to increase enrollment numbers) were based on Fort Lauderdale data with some confirmation of numbers from MetroHealth. The AgeWell charter created in Fort Lauderdale was adapted for use in Cleveland.

PRE-IMPLEMENTATION PHASE

Fort Lauderdale. Much of the planning was carried out in negotiations among AgeWell, Trinity, and Holy Cross during the innovation grant process. A part of the process involved developing the "charter" that outlines timelines, benchmarks, and deliverables precisely. These were developed by AgeWell and leadership at Holy Cross Hospital then submitted to the Trinity Innovation team. Holy Cross participated in developing patient workflows and processes to put the program in place in their setting. This meant alignment of this program with others (e.g., AmeriCorps) and existing care transitions activities among other things.

The decision by Trinity to implement AgeWell at Holy Cross was made based on the disproportionate number of readmissions among patients with Medicare and Medicaid (dual-eligibles) at this hospital, but consideration of the overall numbers of readmissions or the seasonality of admissions was not factored into patient recruitment planning. The Care Coordinator and the AgeWells were recruited, contracted, and employed by AgeWell Global. Recruitment of AgeWells posed challenges until a consultant was hired who had ties in the community and could effectively reach older adults who could serve as AgeWells. This consultant eventually became an AgeWell. The Care Coordinator was first a Holy Cross employee but later transitioned to a full-time AgeWell employee who was provided office space at Holy Cross. The Care Coordinator and Case Manager worked together at Holy Cross in partnership with other similar programs at the hospital. The Site Manager generally manages the AgeWells (leads weekly meetings, ongoing training, review and submission of timesheets, technical issues, etc.). The Care Coordinator triages referral recommendations from the 20/20 system, communicates with the Population Health Nurses, and coordinates any concerns the AgeWells may have regarding patients.

Implementation was eventually delayed in Fort Lauderdale, largely due to some challenges posed by sharing of patient data between AgeWell and Holy Cross. The process of certifying AgeWell Global's data security and transfer arrangements was lengthy and time-consuming and was not anticipated either by AgeWell Global or Trinity. The time spent waiting for implementation was used to provide additional training for the AgeWells regarding local programs and services for which eventual referrals could be made.

Cleveland. Most of the pre-implementation stage in Cleveland was carried out between AgeWell and Fairhill Partners, who in turn negotiated with the Cleveland Foundation. MetroHealth (brought on as the health care partner) was invited but participated minimally in the planning process. Staff assigned to AgeWell at MetroHealth had full schedules and job descriptions for which the addition of AgeWell tasks posed challenges. It was often challenging to engage the appropriate MetroHealth staff in the decision-making and planning that needed to be done. The planning phase of the AgeWell program included establishing the diagnoses to be addressed with the 20/20 platform, examining the number of eligible patients likely to be discharged, establishing the zip codes to be served by AgeWells, developing job descriptions for the AgeWells and the Clinical Coordinator at MetroHealth, determining job qualifications for all positions, and establishing a timeline. AgeWell reported that they had little evidence with which to provide support for major staffing decisions because the Cleveland site was structured so differently from Fort Lauderdale. This lack of clear support was exacerbated by not having an AgeWell employee on site. In the structure that emerged, Fairhill Partners provides the AgeWell site coordinator who is responsible for recruiting and managing the AgeWells. MetroHealth employed the Care Coordinator who refers patients to the AgeWell program and provides clinical support to the AgeWells. AgeWell Global provides training and technical support. AgeWells were recruited, contracted and employed by Fairhill Partners (largely through the Site Coordinator) as paid employees working at most 20 hours per week.

The Care Coordinator role was "poorly scoped" initially because AgeWell had minimal experience with the hospital discharge program model. Initially, it was thought the role should be filled with a nurse, but it was less costly to use a social worker. Later, it was realized that although the social worker's salary might be less, using a social worker was going to require additional hospital resources for clinical support. All partners thought that it was going to require more than a half time position, but budget limitations held the position to halftime, which made it a difficult position to fill. MetroHealth did not hire the Care Coordinator until the AgeWell training process had already begun; she resigned shortly after the first patients were brought on board. The half-time expectations conflicted with the need for the Care Coordinator to be on call whenever AgeWells were working. Eventually this led to limits on the hours that AgeWells could see clients. There were also data collection activities (e.g., charting reasons for patient non-enrollment) that took the Care Coordinator's limited time. The Care Coordinator support role was taken over by the existing care management staff at MetroHealth.

Fifteen AgeWell applicants were screened, interviewed and accepted as AgeWell candidates into training. After training, 12 AgeWells were selected into the program. After background checks, additional volunteer training, and slow enrollment, some of the AgeWells elected did not continue. Ten AgeWells eventually formed the program staff. AgeWells ranged in age from 50-70.

Due to the lack of a Care Coordinator to provide the clinical information components, the training took place over five days instead of six days as initially intended. AgeWell Global provided two trainers and the AgeWell supervisor at Fairhill Partners also contributed to the training. The MetroHealth Care Coordinator had not been hired at the time of the training, and no MetroHealth employees participated in the training. The training included PowerPoint presentations, scenarios, and hands on exercises with the smartphone adapted from materials used in the training in Fort Lauderdale (see Appendix G for highlights of daily training activities).

The AgeWells appeared comfortable with each other and seemed to feel comfortable with the training process, which was well organized. AgeWells appeared to be tracking the presented material and actively took notes. Overall, they appeared to be excited about the program and the training. The phone modules appeared to be helpful and effective (20/20 survey and Google Maps) and provided sufficient depth for AgeWells to use these tools in their work. On the last day of training, AgeWells asked a lot of questions about confidentiality and the limits of confidentiality with their patients and families. It appeared that these concerns would require additional attention in weekly meetings.

The late hiring of the MetroHealth care coordinator and lack of representation of MetroHealth at the training was clearly not ideal and likely led to coordination problems down the road with AgeWells and the care coordinator being unaware of what the other party had been told. Numerous times during the training the trainers explained actions the Care Coordinator would take or responsibilities they would have—it is not clear how well those expectations were actually met

by the Care Coordinator. Overall, the AgeWells felt positively about the training. They reported that the training was clear and informative and that the trainers connected well with the group. AgeWells were satisfied with the amount of training regarding AgeWell smartphone apps (e.g., 20/20).

Key points from pre-implementation phase. AgeWell acknowledged that they needed to engage and ensure that the hospital is on board and invested in the project at each site. In a hospital discharge model, the hospital is a key partner and needs to be engaged as early as possible in the planning process with a program champion. Overall, the evaluators felt that the material presented during the training placed greater emphasis on the 20/20 survey and less emphasis on relationship building than would be expected given the centrality of peer support in the theory of change underlying the AgeWell program. AgeWells were positioned to be an early warning system for health providers as a result of the training but seemed less well-positioned to enhance social support. The evaluators also had concerns that the training did not cover medication management/monitoring and the AgeWells' role in these activities in sufficient depth. In general, AgeWell was strong in the exploration phase with an intuitively appealing program, but weaker in follow-up in the pre-implementation phase. This was in large part because the HDPM was new to AgeWell, and there was not yet clarity on how it would work. Despite having highly skilled AgeWell staff to provide program support, the many details to be handled and processes to put in place were challenging. It is worth reiterating here, that the evaluators focused on the Cleveland program while it was unfolding and examined the Fort Lauderdale program retrospectively. Thus, our findings are more reflective of the Cleveland experience, particularly in the earlier phases of the program.

IMPLEMENTATION PHASE

Fort Lauderdale. In Fort Lauderdale, an AgeWell employee oversees enrollment, and there has been a 79% rate of enrollment among patients approached to participate in the program. The Site Coordinator has access to patient records, and routinely screens new eligible patients and approaches them for enrollment before they leave the hospital. In most cases, the AgeWells are able to meet the patients before they are discharged home. In some cases, they also follow up with patients who are discharged to a nursing facility for a short period of time and pick them up again when they are home. Continuing education on programs and services has resulted in a high rate of social service referrals, and the AgeWells seem to feel well-armed to address any challenge that the patients are facing at home. "Fearless" was used to describe how these AgeWells approach their patients and their work with them.

The relationship building skills of the AgeWell support staff have succeeded at building trust among the partners, which has enabled them to navigate the implementation bumps along the way.

Cleveland. In Cleveland, only 36% of the patients approached enrolled in the program during its early stages. These recruitment challenges were addressed by assigning a "Super AgeWell" to take over patient recruitment once the clinical coordinator resigned. The Super AgeWell was initially more successful with recruiting patients; however, enrollment totals eventually plateaued in the mid-30% range. Unfortunately, very few of the patients are met by their AgeWell before they leave the hospital, and there has been higher attrition from the program once the patient is home. Meeting the patients before they go home seems to be related both to an AgeWell's ability to locate the patient once they are home, and the willingness of the patient to have an AgeWell visit their home the first time. It is easier to turn down a visit from the AgeWell if their initial contact is by phone rather than at the bedside in the hospital.

After initial training, AgeWells meet as a group every Thursday. Evaluation staff attended one meeting in person and others by phone. The meetings begin with the "AgeWell clap" followed by a reflective or motivational reading chosen by the project coordinator. Each AgeWell shares their cases and discussion revolves around resolution of particular challenges or appreciation of successes. Some ideas and strategies were shared—for example, one week an AgeWell shared a list of "get to know you" questions she had developed for starting conversations with her new clients. New cases that need a match with an AgeWell are announced at the end of the meeting. In the meeting we observed, only one of several cases offered was accepted by an AgeWell.

Information gathered from interviews from multiple stakeholders suggested that staffing during the implementation phase was an issue in three ways. First, expectations for the Care Coordinator position were not clear, and the workload and time demands were also underestimated. This position needed to recruit, collect data, answer questions, and fill in a number of data collection tools for AgeWell monitoring and evaluation. Once the program was underway it became clear that it was more than a half-time effort. Second, AgeWell Global changed their support staff at implementation. In the planning phase, relationships among AgeWell, MetroHealth, and Fairhill Partners employees had been forged with guidance from AgeWell's program manager. These relationships were severed at a critical point in program implementation when the AgeWell program manager left the project and was replaced with someone relatively unknown to the rest of the team. This change among key players appears to have affected the implementation and may have fostered some insecurity about roles and expectations for the program.

Working relationships are a key part of program success. Fairhill Partners is a small organization with whom AgeWell had good mission alignment and shared investment in the success of the program. MetroHealth is a much bigger organization. Their key decision makers were unable to be deeply involved in planning, which slowed progress and resulted in decisions being revisited later on. AgeWell was a relatively "big fish" for Fairhill Partners, but a "small fish" for MetroHealth, which resulted in a different level of urgency between the two. The fact that the Cleveland Foundation and Fairhill Partners both contributed financial resources to the project, but MetroHealth did not, perhaps is an indication of the relative priority given to the project. Among

our informants, there was some sense that MetroHealth was willing to take on a project when costs were not an issue, but as expectations for contributions of support and resources grew, their enthusiasm waned.

20/20 Technology

The 20/20 consists of questions and observations that are integral to the AgeWell intervention's "red-flag" pillar. AgeWell's 20/20 has high intuitive appeal: It affords task shifting of some health care roles, responsibilities, and, potentially, costs, to paraprofessionals, allowing these workers to "have eyes and ears" in the homes of patients.

The 20/20 technology is a unique feature compared to other hospital readmission interventions. Most hospital readmission interventions use health care professionals to monitor patients after discharge. Typically, nurses go to the home to educate the patient and family to identify signs and symptoms of potential problems after discharge. The nurse then follows up by phone. If the professional hears about a particular problem by phone, she provides an immediate solution.

In the discharge model pilots, our informants expressed some frustration over the insensitivity of the 20/20 protocol to patient circumstances, emphasizing that the 20/20 should be developed to accommodate specific patient baselines. The tool is calibrated to "average" patients and cannot account for circumstances that might be "abnormal" for typical individuals but normal for a patient recently discharged with a specific condition. The nurses could respond to alerts that could be better understood as typical for a post discharge patient if patient baselines are used to determine change. In addition, AgeWell data errors were noted. Information had been submitted more than once or not submitted at all. And, when appointments were scheduled and changed, or were unable to meet the protocols (i.e., three visits per week in Phase 1) the technology could not be modified to change the protocol to reflect the patient's preference for fewer visits.

Key point from implementation phase. AgeWell managed many challenges during implementation with characteristic flexibility and agility. However, key differences emerged between sites during the implementation phase of the program. These differences may be due in part to the different implementation support approaches enacted by AgeWell. Implementation in Florida was managed primarily by AgeWell employees. The Site Coordinator and Case Manager were AgeWell employees given space to work within Holy Cross Hospital. In Cleveland, implementation support was managed through a training and technical assistance model. Our informants suggest that the absence of AgeWell personnel slowed uptake and contributed to program drift. Face-to-face contact is important for resolving problems and keeping things moving forward. The fact that AgeWell was new to the HDPM and did not have anyone on the ground made implementation in Cleveland challenging.

Table 2. Highlights of Cleveland and Fort Lauderdale AgeWell Pilots

Exploration phase		
Component	**Fort Lauderdale**	**Cleveland**
Partners	AgeWell awarded innovation funding from Trinity Health system. Holy Cross hospital selected as location by Trinity Health.	Adoption negotiated among AgeWell, Fairhill Partners, Medworks, and the Cleveland Foundation; MetroHealth to be hospital.

Pre-Implementation phase		
Component	**Fort Lauderdale**	**Cleveland**
Planning	Holy Cross, Trinity Health, and AgeWell came together to plan. Trinity Health required charter document that addressed full implementation plan. All three entities collaborated to complete the charter.	AgeWell partnered with Fairhill Partners to plan implementation. Occurred shortly after Florida with many plans driven by Holy Cross decisions—"AgeWell in a box" being developed to standardize projects for replication across sites. MetroHealth involved later than Fairhill and AgeWell. Workflows developed with MetroHealth.
Targeted Diagnoses	Chose nine diagnoses. Patient numbers for these diagnoses suggested plenty of clients.	Patient numbers for the same nine diagnoses as Florida suggested plenty of clients.
Staffing	AgeWell hired local consultant to locate and recruit AgeWells. Although described as older adults, 50 and over is the age criteria. Site manager employed by AgeWell. Initial care manager was Holy Cross employee. Both care coordinator and site manager work at Holy Cross.	AgeWells recruited and hired by Fairhill. Although described as older adults, 50 and over is the age criteria. Project manager is Fairhill employee housed at Fairhill; part-time on the project. Care coordinator position posed hiring difficulties. Part-time position housed at MetroHealth hospital.
Training	Training developed for AgeWells with input from care manager and AgeWell program staff. 20/20 technology posed fewer learning challenges than anticipated.	AgeWell and Fairhill provided initial training modified from Fort Lauderdale. Clinical training came later after care coordinator was hired. 20/20 technology posed fewer learning challenges than anticipated. Little information about relationship building or social aspects of patient support.

Implementation phase		
Component	**Fort Lauderdale**	**Cleveland**
Timing	Delayed due to unanticipated IT requirements.	Delayed due to hiring difficulties. AgeWell and MetroHealth staff turnover caused some challenges.
Decision making	Easy access to Holy Cross decision-makers.	Limited access to MetroHealth decision-makers.
Referrals	Social program referrals higher among AgeWell than Holy Cross hospital outreach team.	Few social program referrals.
Patient recruitment	Patient recruitment challenging due to patient census seasonality. Addressed by adding additional diagnoses and patient types.	Patient recruitment challenging due to staff turnover. Super AgeWell worked at MetroHealth to do recruiting.
AgeWell	AgeWells have created a culture of "fearlessness"—strive to solve all patient problems. Ongoing weekly education regarding programs, services and benefits in Fort Lauderdale.	AgeWells express benefits to patients and self. AgeWells reluctant to accept new patients in a timely way, or to work with problems such as pets, smoking, geographic location.
20/20 technology	20/20 technology creates referral recommendations that are "normal" for some individuals despite being red flags in the program. Referral recommendations are then filtered by the care coordinator.	Acceptance of 20/20 technology by patients is a challenge. 20/20 technology creates referrals that add significantly to care coordinator workload.

SECTION IV: THE AGEWELL IMPLEMENTATION SUPPORT SYSTEM

Wandersman's concept of Resource and System Support considers the qualities of the "host" that impede or aid program success (Wandersman, 2009). Host support can be provided through such things as leadership, skills, motivation and buy-in and the capacity of the host can be developed through such things as training, technical assistance and coaching. In the case of the AgeWell HDPM, Holy Cross hospital served as the host for the initial development of the hospital model in Fort Lauderdale, while Fairhill Partners and MetroHealth Hospital served as co-hosts in Cleveland. Wandersman's perspective provides a helpful organizing model that allows us to consider the strengths of the hosts where AgeWell was implemented, while also considering how AgeWell can grow with different hosts in the future.

AgeWell staff talked about the importance of a "landscape analysis" as a step undertaken in previous AgeWell community implementations, but that step was not conducted in either Fort Lauderdale or Cleveland. A landscape analysis considers the context of the community, including population, socioeconomic indicators, important organizational players and other characteristics where the program is to be implemented. In Cleveland, Fairhill Partners provided the knowledge of their community, available programs and services, and the people in the MetroHealth system who could be engaged to support the AgeWell program. Neither site appeared to have a dedicated appraisal of the hospital or health system where AgeWell was being implemented and this absence was mentioned by our informants as a valuable piece that had to be abandoned due to a short planning and implementation window.

In Cleveland, Fairhill Partners played the role of host and exhibited strong commitment, alignment of AgeWell HDPM with mission, consideration of resources and staff, and a clear understanding of the value of the program for Fairhill and their partner, MetroHealth. It's unclear to what extent MetroHealth hospital exhibited full commitment and buy-in for the AgeWell program although all staff expressed a belief in the value of the concept and the fit with the population served by their hospital.

AgeWell invested significant resources with their host organizations through guidance in planning, training, and providing technical assistance from AgeWell consultants to get the programs off the ground. One strategy to ensure that the host has what is needed is to provide it. AgeWell did this through taking the lead on the charter document in Florida, and other planning activities in both sites. The extent to which this strategy is feasible as AgeWell grows into new sites is an important consideration for the AgeWell program.

As we continue to think about the importance of the host organizations, we want to provide a caveat regarding the challenges involved in implementing innovation in health care systems broadly, and hospitals specifically. Prior to the current programs, AgeWell had been a community intervention, run by social service programs, with little affiliation in health care settings. Health care systems and hospitals are not social service providers, despite having missions that address

the needs of vulnerable populations or improving the health of the populations they serve. They are highly regulated, often very large and bureaucratic and have fiscal and financial sustainability as important measures of success. In this respect, AgeWell was entering uncharted territory and learning a new language and new ways to work. As previously described in this report, however, the AgeWell HDPM shares some important characteristics with other hospital readmission reduction programs. AgeWell Global's ability to see how their community model could be developed and applied to the health care space speaks volumes about the entrepreneurial spirit of AgeWell founders and managers. Regarding AgeWell's adaptation to the new health care territory, Coleman and others (Coleman, Rosenbek, & Roman, 2013) have outlined some important strategies for implementing and disseminating programs in the health care arena. Some of those strategies have relevance here.

Coleman and his associates, address model fidelity, staff, implementation strategies with host organizations, and strategies for sustaining and building the programs. In addition to these strategies, the CTI program staff mentions that new interventions should "consider the value of assessing an organization's capacity and readiness prior to implementation of the intervention" (Coleman, Rosenbek, & Roman, 2013, p. 3). This strategy is one that could be included in the landscape analysis that AgeWell staff mentioned. In the CTI model, this step is undertaken with potential adopters to gauge the organization's commitment, alignment of CTI with the organization's mission goals and incentives, available resources and tools (e.g., consider new staff or retraining existing staff) and the development of a business case for the organization. Others (e.g., Rogers, 2003; Flaspohler, Meehan, Maras, & Keller, 2012) have noted the importance of organizational readiness to implement change, new programs, or other activities and both Wandersman and Coleman note the significant role of the host or adopting organization as key to program success.

In our current evaluation, the decisions to partner with Fairhill and MetroHealth and with Holy Cross were driven by the respective funders—the Cleveland Foundation and Trinity Health. Since the funders determined the appropriate hosts for AgeWell, in both cases AgeWell program staff were tasked to develop partnerships where the "marriage" had already been announced. The host organizations agreed to pilot an innovation rather than purchase a service with a proven business case adapted to their own organizations. Both of those factors created situations for AgeWell that may not have been optimal for best success, and the conclusions from our evaluation should always be viewed against that backdrop.

SECTION V: THE AGEWELL COMPONENT

The older adults that AgeWell employs as companions are one of the main pillars of the program. Described as peer-support, they are able older adults for whom employment as an AgeWell (or AgeWell) provides income and meaningful work. In Cleveland, the AgeWells are employees of Fairhill Partners, in Fort Lauderdale they are employed by the AgeWell organization. AgeWells provide companionship, social support, referrals to community resources, and friendship. Sometimes they assist with small tasks such as carrying something or changing a light bulb. According to the recruitment materials, AgeWells "provide companionship visits to other older adults living at home."

According to the recruitment materials developed for use in Cleveland, qualifications include being age 55 or older, good communication skills, and "a sensitivity and compassion" for older persons. The work is sporadic because it depends on the pace of client enrollment. AgeWells work independently and are in charge of managing all of their clients, scheduling their own visits, and determining whether a client is a good match for them. Information about client smoking, pet ownership, and other issues in the household is provided to the AgeWells; they can use this information to choose whether to accept a new patient into their caseload. Initial enrollment went slowly at both sites, and the care coordinator at MetroHealth took on a screening role of reviewing patient information to determine if patients were appropriate for enrollment. Despite meeting age, zip code, and diagnosis criteria some patients were screened out because of family situations (drug use, relatives with mental health issues) or other concerns. The care coordinator and the AgeWell staff determined which patients provided acceptable settings for sending AgeWells into the home indicating that the safety of the AgeWells was a primary concern. In Fort Lauderdale, patients are screened out for end stage renal disease and cognitive issues. Our information does not indicate any other screening (e.g., for family situations) in Florida.

When asked "what makes a good AgeWell?" Staff at both sites talked about "passion" and "compassion," "connecting with people," "listening skills," "grasp of technology," "flexibility," and "good at working with people." Even though some may have clinical backgrounds, they are discouraged from providing any kind of clinical advice. When we asked about the roles and activities of the AgeWells, however, we noted some very different approaches to the expectations of AgeWell. As previously noted, in Cleveland particular concern was given to safety, with the clinical coordinator screening out patients that represented potentially problematic home situations that could jeopardize the safety of the AgeWells. In Fort Lauderdale, the AgeWells were described as "fearless" by more than one of our informants. Thus, this initial philosophy about the kinds of home visits AgeWells were expected to make, the kinds of activities that they undertook and their perception of what was expected of them differed among these two locations. For example, during the Cleveland pilot, early drafts of job descriptions suggested that AgeWells would conduct visits in pairs (presumably to address safety concerns) where necessary although we did not hear of cases where this occurred.

In Cleveland, the AgeWells themselves noted concerns about situations that they did not want to encounter (e.g., pets or smoking) and questions for patients were added to ensure that those AgeWells that did not want to encounter these issues did not have to. While concerns for the safety and comfort of the AgeWells were addressed, this may have resulted in patients not getting matched with an AgeWell in a timely manner once these issues had been identified. It also illustrates a tension between a companion role that is developed to be mutually beneficial to the older adult AgeWell and the clients they serve. A successful discharge model, however, relies on serving all patients in need of support, not just a particular subset. (Appendix H includes a summary of findings from a focus group with AgeWells for additional information.)

Other areas of difference also included the practice of community referrals. In Fort Lauderdale, extensive continuing education was provided during AgeWell weekly meetings regarding community programs and resources. This was a useful opportunity provided by the slow patient enrollment. The development of this expertise paid off—our informants reported that the Fort Lauderdale AgeWells ended up making many social service referrals and feeling as though there was a resource to address every patient issue. This was less true in Cleveland, where social service referrals were provided primarily by the site coordinator. At a meeting several months into program implementation, it was mentioned that no social service referrals had been made by any of the AgeWells. The companions responded that some referrals had been made, but discussion revealed they were not recorded in the proper place in the 20/20; thus, they weren't counted.

In Cleveland, AgeWells described mixed reactions to the 20/20. The 20/20 is repetitive, and sometimes patients tire of answering the same questions. One AgeWell indicated that they would like to reword them just to keep things interesting, while others pointed out the importance of "asking the questions the way they come up." Others mentioned having patients whose answers generate a referral every time, despite the fact that those problems are "normal" for them. Despite the patient knowing that their answers are the same, the patient and the AgeWell arrived at a shared understanding that the AgeWell has to ask the 20/20 questions. They agreed that you "can't take for granted" what the patient answers are, so the questions must be asked.

When asked about surprises, most agreed that the slow enrollment and the low number of clients they had were surprising. Some had thought that they would be able to rely on AgeWell for a regular paycheck and had experienced disappointment in that regard.

AgeWells shared their perceptions about the benefits of the AgeWell program to their clients, and the benefits of the program to them as they serve as AgeWells. Interestingly, none of the AgeWells mentioned the 20/20 technology as a benefit to patients or themselves.

Benefits to the clients included:

- Improvements in health; healing
- Having someone to talk to about their health
- Having companionship, enjoyable interactions, feeling cared about, making new friends

- Having regular visits, telling stories
- Getting additional information about community support

Benefits to the AgeWells included:

- Positive feelings about the program—keeping seniors at home, providing encouragement to clients, individual choice to improve
- Relationships—with clients, with other AgeWells, having someone to talk to
- Meeting new people, learning new things, making new connections, getting into the community
- Personal satisfaction, growth through helping others, improved feelings, compassionate service, fulfilling a calling, feeling appreciated, giving back
- Weekly meetings, flexibility of work schedule, money, social aspect of the AgeWell group

SECTION VI: FINDINGS AND RECOMMENDATIONS

SUMMARY OF FINDINGS

The literature on care transitions interventions is inconclusive in many respects and does not provide a clear roadmap for AgeWell to follow in adapting HDPM to reduce hospital readmissions. However, some key points provide support for the likelihood that the AgeWell program can be one component in an effective care transitions program implemented by a hospital or in conjunction with a community partner. The strengths that we note are the following:

1. The AgeWell program provides important post-hospital follow-up by a single support person, with backup from licensed health professionals.
2. Sign and symptom identification is provided via the 20/20 platform. The hospital-based care coordinator provides professional advice regarding sign and symptom management and makes determinations about strategies needed to prevent symptoms from escalating into problems. The 20/20 also identified social support needs such as food insecurity, needs for medication refills and environmental concerns.
3. A multi-disciplinary team includes the community-based AgeWells along with a hospital-based nurse and physician backup. These components provide health care expertise along with peer support and an intensive program of visiting from the AgeWells in a more cost-effective way than a similar program based only on licensed health professionals.
4. The more components that are offered in a care transitions program the greater the likelihood of success in reducing hospital readmissions. Thus, AgeWell provides an additional intervention or service to supplement activities already undertaken by a hospital or health system.

Additional opportunities can be explored as the AgeWell hospital discharge program develops. Based on what has been learned, these may include assisting AgeWell with effective strategies for engaging family members and informal caregivers in symptom management, intervening earlier in the hospitalization to develop rapport before discharge, and training AgeWells in effective strategies to support older patients as they learn to self-manage their disease and recovery.

The intuitive appeal of AgeWell is a strength in selling the program during the exploration phase. A clear strength of the AgeWell Global organization is their flexibility in response to shifting needs and priorities from the host organization and their agility in exercising this flexibility. The upside of this flexibility is that program design has been responsive to the shifting demands of the host organization, essentially customizing many attributes of the intervention to meet the needs of the host communities. The hospital is a key partner in the HDPM and needs to be engaged as early as possible in the planning process.

The AgeWell training in Cleveland was effective overall and the depth and pace of the training was appropriate. Overall, the evaluators felt that the material presented during the training placed greater emphasis on the 20/20 survey and less emphasis on relationship building than would be expected given the theory of change underlying the AgeWell program. AgeWells were positioned to be an early warning system for health providers as a result of the training but seemed less well positioned to enhance social support. The evaluators also had concerns that the training did not cover medication management/monitoring and the AgeWells' role in these activities in sufficient depth.

RECOMMENDATIONS

The four recommendations that follow were developed after extensive discussion and review of interviews, deep-dive materials, meeting notes, and two debrief meetings of the evaluation team. They represent our consensus and are geared towards assisting AgeWell in moving forward with their hospital discharge model. While many of the suggestions could be applied to the community model they may also not be applicable, because we did not observe an implementation of that model. We hope these provide some useful points of discussion and an agenda for future actions for the AgeWell Global team.

RECOMMENDATION #1: ASSESS ORGANIZATIONAL READINESS TO FACILITATE UPTAKE

AgeWell should identify and assess critical components of organizational readiness to facilitate uptake of the intervention in future iterations. Program adoption experienced significant challenges in each setting. These varied in intensity ("arriving to little fanfare" at Holy Cross Hospital, efforts abandoned in other locations). It is clear readiness varied across organizations and among levels within the organizations. Research on implementation and readiness for change suggests that inattention to forces and factors that impact adoption seriously jeopardizes any project seeking to introduce a new idea into an organization (e.g., Rogers, 2003). Readiness, therefore, becomes a crucial planning and surveillance activity. Scacia and colleagues (2015) propose readiness is composed of three essential factors summarized by the equation $r = mc^2$ (readiness = motivation X general capacity X innovation specific capacity). AgeWell should attend to these factors in future efforts to implement the program.

Motivation. As observed in both of these pilots, the AgeWell program has intuitive appeal. It "fits" a health care need. It aligns with the mission of many health care institutions and has the potential to create multiple impacts.

In these two sites, motivation of the key partners (Fairhill, Trinity) was strong during pre-implementation. Enthusiasm for the project was slow to come about in Holy Cross, where informants observed the program was "met with little fanfare," although the program was embraced and well supported by staff at Holy Cross. Enthusiasm from MetroHealth was slower than at Holy Cross and also seemed uneven among the key players. The motivation of the hospital settings needed cultivation to move the project forward. Medical partners need "skin in the game" and those who will actually be charged with implementing the program need to be engaged early in bringing AgeWell into their organizations. In both Florida and Cleveland, the medical partners (Holy Cross, MetroHealth) were the last key partners to be involved in the planning process with different results. In Florida, the medical partners had deeper involvement; the grant process required engagement in the planning process. Once Holy Cross hospital was chosen, AgeWell and Holy Cross developed a charter and collaborated with a Trinity Health representative at every step.

In Cleveland, MetroHealth's involvement in planning was a struggle. Given the integral role of the medical partner in recruiting and monitoring patients, future efforts should assure that representatives from the medical partner are involved fully in the planning and pre-implementation processes. Neither hospital was averse to adopting the program because it is inherently compelling; however, resource demands were presumed to be minimal since programmatic costs were paid by external grants. As planning and implementation rolled out at both sites, it became clear that hospital staff time and effort was much more than minimal, because the HDPM cannot be placed into a hospital without major integration into existing workflows and processes. In Cleveland, the motivation of AgeWells was initially strong but tempered by delays between training and kickoff.

This raises the important question of whether hospital partners are motivated and ready to "buy in" to AgeWell—both literally and figuratively. Interviews with health care leadership suggest that, even with compelling emerging data, it is unclear whether they would invest in AgeWells rather than allocating the resources to clinicians, similar to those recommended in the CTI model, who can provide health care advice to patients. These pilots showed that when offered without cost, the hospitals were happy to take it and use it, while continuing to exhibit reluctance to purchase the program. The critical question becomes "Is the host setting motivated and engaged to achieve program success?"

Capacity. Flaspohler and colleagues (2008) posited that capacity can be conceptualized as two types with three levels. In terms of types, capacities may be innovation specific (knowledge, skills, and abilities related to the particular program or service being adopted) or general (knowledge, skills, and abilities associated with the adoption of any innovation). In terms of dimensions, capacities are differentiated into individual, organization, and community. General capacities are resources that are relevant for the program and in the case of AgeWell, defining what those capacities are is a recommended next step. Host capacities such as staff to assist with integrating AgeWell into existing care transitions activities, clear data sharing arrangements, legal agreements and contracts, and physical space for patient recruitment/enrollment work to take place, are examples of capacity issues that arose in these pilot sites.

Innovation specific capacities are skills (at the individual level) and human, technical, and fiscal conditions (at the organizational level) which are integral to a particular innovation. For AgeWell, individual innovation specific capacities need to be understood for multiple roles in the organization including companions, care coordinators, site managers, and others. Distinct differences in individual capacities emerged between implementation sites (e.g., a culture of "fearlessness" in one site) that impacted enrollment of patients into the program. The agile flexibility of AgeWell global employees in Fort Lauderdale may be difficult or impossible to replicate when implementing the program through training and technical assistance as was done in Cleveland. Uncertainty regarding innovation specific capacities may have facilitated program drift. The malleability of the AgeWell intervention complicates identifying innovation specific capacities. As AgeWell Global proceeds, it will become increasingly important to distinguish between the core components and adaptive features of AgeWell.

RECOMMENDATION #2: DETERMINE HOW AGEWELL HDPM FITS WITH THE EXISTING CARE TRANSITIONS/READMISSION ACTIVITIES

In both of these pilot initiatives, AgeWell was implemented alongside already existing care transitions/readmission reduction programs. This is not uncommon—beginning in 2013, hospital Medicare reimbursement rates were reduced in hospitals with high readmission rates, and most hospitals in the U.S. have worked on care transitions/readmission to avoid those reductions. Evidence suggests that many hospitals have already gained most of the readmission reductions they are likely to achieve, with most of the reductions occurring between 2013 and 2016, and little progress since (Lee, 2017), although AgeWell's success at reducing 30- and 90-day readmissions in Fort Lauderdale may indicate otherwise. As AgeWell attempts to find their niche, they are unlikely to find health care systems waiting for a new stand-alone intervention to put in place. The best care transitions programs use multiple approaches, and AgeWell could be an effective add-on approach, just as it was at Holy Cross and MetroHealth where it was integrated into the workflows of existing programs. Standardizing a process for developing workflows and assessing how AgeWell fits with existing programs will allow AgeWell to effectively find the areas needing modifications and the areas where AgeWell brings in strengths.

In particular, AgeWell presents an opportunity to address the particular challenges of patients with low social support. Social isolation has been shown to be particularly harmful for older adults and is estimated to cost the Medicare program an additional $6.7 billion annually (Flowers et al., 2017).

Understanding the contribution of the AgeWell program to socially isolated older adults, in conjunction with existing care transitions programs would seem to be a promising area of future exploration for AgeWell. As previously noted, the AgeWell training in Cleveland did not provide much emphasis on social support which is an important component of their theory of change. Rather than targeting particular diagnoses, zip codes, or payer types which may already be the focus of readmission reduction, an AgeWell focus on older adults going home with limited or no social supports suggests potential benefits. In particular, previous studies have found that having non-kin support is associated with fewer hospitalizations and a lower likelihood of nursing home admission. Other studies show that these relationships depend on the type of social support and the type of health service use being examined (Shaw, et al., 2017). These complex relationships suggest an opportunity to study AgeWell as an intervention to modify social isolation and examine associated effects of overall health care use. As Medicare moves towards Value-Based Payments and increased participation in Advantage programs, initiatives that shift health care utilization from nursing home to home, from ER to primary care provider or otherwise impact the quantity and type of utilization have particular appeal.

RECOMMENDATION #3: STRENGTHEN AND SYSTEMATIZE PEER COMPANIONSHIP

The literature on the success of peer support programs in health care is mixed, while being almost completely absent regarding the effectiveness of peers on hospital readmission reduction. The CTI protocol specifically says that "The Care Transitions Program does not endorse the use of paid or volunteer layperson Transition Coaches" (Coleman, Rosenbek, & Roman, 2013, p. 4). Thus, the role of peer companions as used in AgeWell lacks much precedent and guidance. We recommend several areas where the AgeWell role can be better defined to ensure program success.

Systematize the peer role. As learned in these two pilots, the AgeWells were passionate, compassionate, and dedicated to their roles and belief in the programs. However, our interviews and observations in Cleveland suggest that there were differences among the AgeWells regarding their willingness to "do whatever it takes" to work with a patient, solve problems on the patient's behalf and accept and begin work with patients in a timely manner. While the Cleveland AgeWells were driven by mission and calling it seemed clear that some perceived their role as a job, with associated responsibilities, while others acted more as volunteers with reimbursement and felt less obligated to their role. The Fort Lauderdale AgeWells were "fearless" and perceived every patient problem as one they should solve. The reported difference between the two pilots in terms of the volume of social service referrals illustrates some of the area where clearer expectations might be helpful.

Another issue regards AgeWell use of the 20/20. AgeWell data errors were noted and information had been submitted more than once or not submitted at all. Monitoring of data and training or exercises beyond the initial training may be helpful to reduce AgeWell errors in using the 20/20.

A systematic protocol might include some or all of the following as well as other issues. These can be built into training, into quality monitoring of AgeWell performance or other arrangements that formalize the importance of a working relationship.

- Specific criteria regarding patient issues that result in ineligibility for the AgeWell program
- Specific expectations regarding AgeWell acceptance of patients, and time to first contact once a patient has been assigned
- Specific expectations regarding the caseload an AgeWell would be expected to carry
- Specific expectations regarding completion of 20/20 assessments, regularity of contact or attempted contacts with patients, or other benchmarks
- Specific expectations regarding social service referrals or other activities beyond the visit and the 20/20 interview
- Specific criteria to match AgeWells in terms of the characteristics of the patients they serve

Strengthen the peer role. While this is paid employment for AgeWells, the Cleveland AgeWells perceived the benefits in terms of relationships and interpersonal support. In other words, their role as companions and peers was front and center, with much less attention given to referrals—either to community services or via the 20/20 technology. With a clearer definition of what is expected of AgeWells, the nature of the AgeWell HDPM also becomes more clearly defined.

Additional follow-up and ongoing education can, and should, supplement initial training. AgeWells raised many questions during the training regarding confidentiality and the limits of confidentiality with their patients and families. They also asked many questions regarding their role in helping patients understand questions on the 20/20. Despite being one of the pillars of the HDPM, training on medications was limited—some additional follow-up once they have begun working with patients would be useful. As AgeWells begin working with patients, topics and challenges they are addressing are brought to the regular group meetings. Lists of questions for "getting to know someone" were provided in the weekly meeting we observed. Such strategies for building rapport and relationships can also assist in making these companions more effective peers.

RECOMMENDATION #4: REFINE AND VALIDATE THE 20/20 TECHNOLOGY.

Validity is a challenge for any assessment used to identify the impact of a particular issue or "red flag." The 20/20 has face validity. It was developed in collaboration with experts in the medical field. From their knowledge and experiences, these experts developed an algorithm from a list of pre-determined yes/no questions and observations. The reliability of the tool and data collection appears good. Evidence suggests that AgeWells are appropriately documenting signs and symptoms similar to what supervisors objectively see when visiting.

What is not known is the predictive value of the 20/20 tool. In the case of the AgeWell intervention, does a referral recommendation (red-flag) follow-up decrease the likelihood of hospital readmission? Without a more rigorous examination with a control group, it is hard to say with certainty that the identification of referral recommendations is having any impact on reducing hospital readmissions.

A more integrative system would streamline some of the key data collection and data management efforts. A strategy for including a user-friendly data collection effort for medication management is suggested. Second, the system does not allow for rescheduling appointments.

In closing, it is worth noting that the AgeWell Global staff is highly entrepreneurial, motivated, dedicated, and skilled. They have learned a great deal in the last 16 months, along with this evaluation team. As part of project close-out, a debrief strategy to capture what has been learned and to consider what might have been done differently will help them chart a course for their future initiatives.

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APPENDIX A: FIRST YEAR EVALUATION TIMELINE AND ACTIVITIES

(Major Cleveland milestones in italics)

January 2017-July 2017

- Visited AgeWell Henry Street closing in NYC
- Participated in weekly calls between AgeWell Global and Fairhill Partners in Cleveland
- Participated in partnership and planning meetings in Pittsburgh
- Received and reviewed AgeWell documents related to job descriptions, timelines, discharge diagnoses, workflow. Provided written feedback to AgeWell regarding its post-implementation data collection efforts (client satisfaction, partnership feedback, AgeWell's preparedness to visit participant)
- *April 10th-11th: First site visit in Cleveland with AgeWell Global, Fairhill Partners, and MetroHealth:* RWJ evaluators attended site visits between AgeWell Global, Fairhill Partners, and MetroHealth in Cleveland
- *June 21st-June 27th: Five-day AgeWell Training in Cleveland*
- Observed five-day AgeWell training in Cleveland. Following the completion of the training, RWJ evaluators interviewed 15 companions regarding training effectiveness
- Produced and presented to the AgeWell Global work group a white paper entitled, "Social Support: Importance, Effectiveness as an Intervention, and Considerations for Success"

August 2017-October 2017

- *August 15th: MetroHealth and Fairhill Partners began recruiting participants at MetroHealth*
- Participated in calls between MetroHealth, Fairhill Partners, and AgeWell regarding first week activities. RWJ provided insight into the need for MetroHealth to track those who chose not to enroll and its importance for future evaluative efforts
- Attended by phone the AgeWell supervisory meeting held once a week between AgeWell supervisor and AgeWells
- Completed one-hour long interviews with key stakeholders from AgeWell Global (N = 4), Fairhill Partners (N = 2), MetroHealth (N = 2) regarding partnership, planning, and implementation activities to identify what worked in Cleveland, what did not and what could be done differently in future sites

- Produced a white paper entitled, "Reducing Hospital Readmissions: Effectively Intervening at the Hospital to Home Transition"

- Presented the white paper to a larger AgeWell Global work group. Discussion followed focusing on the findings. AgeWell discussed the desire for more information related to retention and enrollment and retention of discharge patients in the AgeWell program at MetroHealth and Florida

November 2017-February 2018

- Visited Fairhill Partners and conducted interviews with program staff (AgeWell Supervisor, Super AgeWell) regarding recruitment and retention of discharged patients. Completed a discussion group with the AgeWells

- Conducted telephone interviews with two of the four Care Coordinators and Renee Pennington at MetroHealth hospital

- RWJ evaluators call with AgeWell Global/RWJ to discuss potential for no-cost extension. New activity would include retrospective formative interviews with staff in the Fort Lauderdale evaluation

- Completed one-hour long interviews with key stakeholders from AgeWell Global (N = 6), Holy Cross Hospital (N = 4), and Trinity Health (N = 1) in Fort Lauderdale Florida

APPENDIX B: CLEVELAND FORMATIVE INTERVIEW PROTOCOL

Interview Protocol AgeWell

We are conducting these interviews to obtain a better understanding of the adoption and implementation of AgeWell in Cleveland. We're going to talk about how AgeWell was formalized, how plans were made, and how recruiting, selecting and training AgeWells proceeded. We will ask you to describe things that went well, things that did not go well, and how that particular stage may be improved in future iterations.

REACH Stage

To begin, we want you to think about your first involvement (in any way) with the AgeWell process ending with a formal commitment to implement AgeWell in Cleveland. We'll call this the partnership phase.

1. What made the AgeWell program more appealing than other hospital readmission interventions to (Fairhill Partners/MetroHealth)?

2. Tell us the story of how you moved from "possibly" to a "yes" with implementing the AgeWell intervention.

3. What had to be worked out on your end to move from "possible" to "yes"?

4. What capacities (e.g., leadership, staff hiring and training, space, buy in) were present or missing at your site that influenced your commitment to the AgeWell intervention?

5. Could/Should the decision have happened faster?

6. What were some of the critical ingredients necessary to ensure that "Yes to AgeWell" occurred at your site?

7. What went well (helped move AgeWell along)?

8. Were there things that did not go so well?

9. What advice would you have for AgeWell in their future efforts in building partnerships?

10. Are there things you'd wish you'd known when you started thinking about partnering to do AgeWell?

Planning Stage

Next, we want to focus on the Planning stage. This stage includes the steps taken after deciding, "Yes" to partner with AgeWell and goes to the recruitment of AgeWell peers.

There were a lot of things that had to be worked out in order to get AgeWells in place and ready to be trained.

1. What were some of the most important issues that needed to be worked out at your site?
2. How was the need for AgeWell's post-discharge intervention in Cleveland determined?
3. How was target population chosen?
4. How did adoption of the AgeWell intervention fit in with the goals of your site?
5. How was the implementation plan developed?
6. Could/Should the planning phase have gone faster?
7. During the "Planning Stage" what things went well (helped move AGEWELL along to AgeWell recruitment and training)?
8. Were there things that did not go so well?
9. What would you change if you were doing this again?
10. What advice would you have for AgeWell in future efforts during the planning stage?
11. Are there things you wish you'd known when you started the planning stage?

Recruitment

We want to focus on the recruitment phase. This stage begins when the AgeWells are recruited and agreed to participate and ends when they were selected and ready to begin work.

1. Tell me us how your site recruited AgeWells.
2. What things went well regarding recruitment?
3. Were there things that did not go so well?
4. What would you change if you were doing this again?
5. What advice would you have for AgeWell in future efforts during recruitment?
6. Are there things you wish you'd known when you were first thinking about recruitment?

Training

1. What things went well regarding training?
2. Were there things that did not go so well?
3. What would you change if you were doing this again?
4. What advice would you have for AgeWell in future efforts during the Training stage?

5. Are there things you wish you'd known when you were first thinking about the training phase?

Selection

1. What factors went into selecting an AgeWell?
2. What would you change if you were doing this again?
3. What advice would you have for AgeWell in future efforts during selection of AgeWells?
4. Are there things you wish you'd known when you were first thinking about AgeWell selection?

APPENDIX C: FORT LAUDERDALE FORMATIVE INTERVIEW PROTOCOL

Holy Cross and Trinity Staff

For Holy Cross & Trinity staff

We are conducting these interviews to obtain a better understanding of the adoption and implementation of AgeWell in Holy Cross hospital in Fort Lauderdale. We're going to talk about how the partnership between AgeWell and Holy Cross developed, how plans were made, and about steps towards implementation and the challenges and successes as AgeWell service began. We will ask you to describe things that went well, things that did not go well, and any ideas you have for improving AgeWell in future locations.

To begin, we want you to think about your first involvement with the AgeWell program. We're thinking about this as the partnership phase.

1. Tell us the story of how you first heard about the AgeWell program. What were your initial thoughts?

2. How did you integrate the AgeWell intervention into other programs and activities at Holy Cross?

3. What issues (e.g., leadership, contracts, IT arrangements) had to be worked out to forge the partnership?

4. Were those issues resolved in a timely way? If no, what slowed things?

5. What went well (helped move AgeWell along)?

6. Were there things that did not go well?

7. What advice would you have for AgeWell in their future efforts in building partnerships? Think about the most important things they should keep doing, as well as the things they might want to change.

Planning Stage

Next, we want to focus on the Planning activities. These were things such as selecting the kinds of patients to target, the strategies for recruiting and training AgeWells, the protocol for the number and timing of visits, and other similar things.

1. Tell me about your involvement in planning for the AgeWell program at Holy Cross.

2. What were some of the MOST IMPORTANT elements that AgeWell and Holy Cross/Trinity needed to get in place in order to launch program?

3. At Holy Cross, how was target population chosen?

4. How was the implementation plan developed? (i.e., Who was at the table?)

5. During the "Planning Stage" what things went well?

6. Were there things that did not go so well? (i.e., Were the right people at the planning table?)

7. What advice would you have for AgeWell in future efforts during the planning stage?

AgeWell Recruitment & Training

1. How was Holy Cross involved in getting the AgeWells on board and trained? *(I think the answer will be "not very much" so the following questions may not apply. And we know this story from Jewel already—if we have good notes from Jewel's story that day.)*

2. What things went well?

3. What would you change if you were doing this again?

4. What advice would you have for AgeWell in future efforts during the Training stage?

5. Are there things you wish you'd known when you were first thinking about the training phase?

Implementation

6. What are the strengths of the way the AgeWell program is structured at Holy Cross? (By structure, I'm thinking about what would be different if the AgeWells and care coordinator were Holy Cross employees. How does that affect data and record access? What about space and integration of the AgeWell staff into Holy Cross programs and system? Anything else?)

7. Can you describe the patient recruitment process in FLL? (i.e., Are they doing any pre-selection/exclusion of people based on notes/hospital observations?)

8. Recruitment has been challenging in both FLL and Cleveland. What are the important lessons you've learned that should be part of AgeWell protocol going forward?

9. What about your role could be done differently?

10. How are things going with the 20/20 technology platform? (e.g., What about additional documentation outside of the survey?)

11. Were there things that surprised you as the AgeWell program began rolling out?

Thinking about AgeWell overall, in closing….

1. What advice would you have for AgeWell as they begin working with more hospitals in the future?

2. Are there things you wish you'd known when you were first thinking about AgeWell at Holy Cross?

3. What would need to happen for AgeWell to be sustainable at Holy Cross?

4. What do you think the main value of AgeWell is for hospitals?

APPENDIX D: AGEWELL FOCUS GROUP PROTOCOL

AgeWell Discussion Group

Want to hear from everyone, so if you haven't spoken up I may call on you. If you have been talking I may ask you to give someone else a turn.

Please don't all talk at once. We're trying to record this so we can remember all you said and if you all are talking, we'll have nothing we can use.

We want this to be a safe space. I know a lot of what you tell me today you've already talked about in your weekly meetings but please know that what you say here is not going to have your name attached in anything we write up about what we learn.

Please don't repeat what you hear others say here today.

1. Let's begin by getting a quick update from each of you. How many patients have you worked with in total, and how many are you working with now?
2. Describe for me what a typical AgeWell 1st visit is like.
3. How do the visits change after you've gotten to know the patient?
4. What are the biggest challenges you face in working with patients?
    a. Recruiting?
    b. Following the protocol for the timing and number of visits?
    c. Building rapport?
    d. Role of family?
    e. Disenrollment?
5. Can you share some ideas you've tried or want to try to address those challenges?
6. Do any of you have a success story you can share with me?
7. How is it going working with the 20/20 technology platform?
8. What have been the biggest challenges and/or best things about the 20/20 technology?
9. How do the patients respond to the 20/20 questions and technology?
10. What things have been surprising as you've started work? Can you give me one or two things you would change about the training to address those surprises?

Now I'd like to shift gears a little and think about the AgeWell team.

11. Tell me about working with the care coordinator(s) at MetroHealth. Can anyone tell me about the last time you talked with one of them about a problem or issue?
12. What are the biggest challenges you face in coordinating your work with MetroHealth?
13. Can you share some ideas for addressing those challenges?

Now I'd like to know about the support you get from Fairhill.

1. Tell me about the kinds of things you discuss in these meetings every week.
2. What other kinds of support do you get?

INDEX CARDS

1. Take five minutes to write down AND strive for consensus on top three - five things altogether
2. Three - five benefits of AgeWell to the patients you work with
3. Three - five benefits to you of being an AgeWell

APPENDIX E: INTERVIEW WITH AGEWELL SUPERVISOR CLEVELAND

GOAL—to learn what works and changes that are needed in next location

Let's begin by with a quick update. How many patients have you worked with in total, and how many are you working with now?

1. What are the biggest challenges you face in working with patients?
    a. Recruiting?
    b. Following the protocol for the timing and number of visits?
    c. Building rapport?
    d. Role of family?
    e. Disenrollment?
2. Can you share some ideas you've tried or want to try to address those challenges?
3. Can you tell me about any other things that have been surprising as this has rolled out and the AgeWells have started working with patients?
4. Can you give me one or two things you would change about the training or planning phase to address those surprises?
5. Tell me about working with the care coordinator(s) at MetroHealth.
6. What are the biggest challenges you face in coordinating your work with MetroHealth?
7. What have you tried to address those challenges?
8. Now I'd like to know about the support you provide here. Tell me about the kinds of things you discuss in these meetings every week.
9. What other kinds of help have you provided?
10. What would you do differently if you were planning to roll out this program again?

APPENDIX F: INTERVIEW WITH METROHEALTH CARE COORDINATOR CLEVELAND

1. Tell us how this AgeWell intervention fits into the larger MetroHealth care coordinator/care transition model of discharge planning.

2. If you were able re-design the Care coordinator role within the AgeWell intervention what would you do?

3. Once a client has been identified as eligible, how do you determine suitability?

4. What has gone well regarding recruitment of AgeWell patients?

5. Are there things that are not going so well?

APPENDIX G: HIGHLIGHTS OF DAILY TRAINING ACTIVITIES

Day 1 highlights (June 21st, 2017):

Introductions and discussion of the key components of the program: role of AgeWells, Project Director, Clinical Coordinator, Tech Support

Discussion of potential patients and their conditions that AgeWells will work with in the community

Introduction to the smartphone and subsequent Q & A

Day 2 highlights (June 22nd, 2017):

Identifying issues with patient's basic self-care

How to properly communicate with patients

Personal safety before and during home visits

Introduction to and practice with to the 20/20 app on the smartphones

Day 3 highlights (June 23rd, 2017):

The life of an AgeWell

How the Referral to AgeWell process works

Overview of Medication Management and Q & A

Additional smartphone training

Day 4 highlights (June 26, 2017):

Monitoring Common Health Problems

Making Homes Safer

Smartphone learning lab

Day 5 highlights (June 27th, 2017):

Smartphone learning lab: how to email and check calendar

Practice using smartphone

Final Quiz: 2 Workstations

Graduation

APPENDIX H: SUMMARY OF FINDINGS FROM CLEVELAND AGEWELL FOCUS GROUP

Following a brief meeting in September, evaluation staff facilitated a discussion group with the AgeWells. The discussion was scheduled to learn how things were going after every AgeWell had at least one client in the program. The discussion centered around three main topics: 1) the AgeWell visit experience, 2) their relationships with the patients, and 3) benefits and challenges of the program.

Initial AgeWell visits were arranged either via a phone call or an initial visit in the hospital (the preferred arrangement). At the first visit there was usually a discussion of the hospital stay and some discussion about the medications. One of the AgeWells described the initial visit as "scary" because you don't know what to expect or what you will find when entering a home for the first time. They also talked about how the relationship evolved over time. When discussing ideas for how they got to know their patients, they described specific strategies such as asking about their favorite things, their families, and where they grew up. Most mentioned asking about the client's families and details of their lives. One AgeWell had shared a list of "getting to know you questions" she had found on the internet. She described them as things to get the client talking and sharing. She agreed to distribute the list to the group for their use as well.

After getting to know each other, the AgeWells described forming a bond with their patients and looking forward to spending time together. Some of them said that they were able to provide more emotional support instead of just going through the 20/20 questions. And finally, the conversation became more shared, with the patient interested in learning about the AgeWell, not just the AgeWell learning about the patient's needs. Some of them had success stories that they could tell, and several mentioned continuing the relationship with the patient after the patient had finished the program.

The most common challenge reported by the AgeWells was following the protocol for the timing and number of visits, particularly in Phase 1 with three visits the first week. Early communication is poor. Patients may not receive or return calls from AgeWells. Patients are often busy with visitors after discharge. They may not feel up to receiving other (especially unknown) visitors. The AgeWells found that many patients who initially agreed to the service before discharge reconsidered and withdrew from the program when they returned home.

Family members have been found to be both a benefit and a challenge. In some cases, there have been uncomfortable situations with families feeling as though the AgeWell is in the way, and not understanding the role of the AgeWell. Some described challenges in the environment including smoking, pets, and unsafe neighborhoods. AgeWells were also able to share some positive stories regarding interactions with family members. One talked about being able to communicate with a daughter when they had not been able to reach the patient.

The meeting closed with the AgeWells providing a summary of benefits to themselves and their patients, as described in the larger report.