

PROUD PARTNERS



Home for Life

Adena Health System/National Church Residences

COPD Executive Summary

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Adena Health System, an independent, not-for-profit and locally controlled health care organization in south-central Ohio, partnered with National Church Residences, the nation's largest not-for-profit provider of affordable senior housing, from April 2016 to December 2017 to integrate an Enhanced Service Coordination Program, called *Home for Life*. The pilot was specifically designed to study the Chronic Obstructive Pulmonary Disease (COPD) population in an effort to meet the Triple Aim objectives by addressing social determinants of health. The program engaged 100 COPD patients who were currently enrolled in the Medicare Shared Savings Program at Adena Health System. The goal of the one-year COPD pilot included: readmission reduction to a rate of 17.6%, reduction of health care spend by 10% and the continuation of high patient satisfaction and quality of care.

Program Design and Implementation: Adena selected 201 patients who were considered high risk based on risk stratification methods provided by Conifer Health Solutions. The 201 patients selected were recruited for program participation, with 100 of the 201 patients opting into the COPD pilot. The Enhanced Service Coordinator met with all 100 patients to complete evidence based assessments determining specific needs and interventions to address the social determinants of health. The Enhanced Service Coordinator then communicated the status of patients to a COPD Nurse Navigator. Weekly huddles and monthly inter-disciplinary care meetings were held to address barriers, discuss patient status and review clinical and business outcomes.

Data Analysis and Outcomes: Upon the one year completion of the COPD pilot program, the Triple Aim outcomes were reviewed and analyzed to determine program success. Over the course of the COPD pilot program, the overall health care spending decreased by 15% and the readmission rate was reduced to a readmission rate of 14.6%. The patient satisfaction component of the COPD pilot program needs to be further explored for this population. A satisfaction survey was completed but after reviewing question components it was determined that the data gathered was not conducive to accurately measuring patient satisfaction.

Discussion and Conclusion: Over the course of the *Home for Life* pilot, the partnering organizations encountered various barriers and limitations to program evaluation. These limitations are discussed in reference to three overarching categories. These categories include: data and financial management, operations management and communications management. Based on the data analysis and review, to date, two of the three goals of the Triple Aim were met. As a result, Adena Health System and National Church Residences will further conclude the patient satisfaction component and have started discussions regarding next steps and advancing the implementation.

Introduction

As healthcare continues to move from a volume based care delivery model to a value based care delivery model, hospitals and various health care providers are tasked with coordinating care across the care continuum. In an effort to facilitate the transformation of care delivery to a value based model, Medicare began to offer various Accountable Care Organization (ACO) programs. The intent of ACOs is to allow health care providers to manage the health of a population by taking responsibility for cost as well as the quality of patient care. Adena Health System, a large hospital system located in southern Ohio, opted to participate in a Medicare Shared Savings program, a Medicare ACO option, aiming to effectively manage the health of 2,000 patients. Adena focused on the Triple Aim when establishing their population health management approach, which consists of improving the quality of care as well as patient experience, while simultaneously reducing cost. To meet the Triple Aim goals, Adena focused on adapting to ensure the patient was provided quality care across the care continuum. Adena concentrated specifically on impacting the patient once the patient transitioned home and was no longer in an Adena facility.

In 2016, in partnership with Partners for a Healthier Ross County, Adena Health System conducted a Community Health Needs Assessment to gain a better understanding of resident demographics around disease and health management, as well as specific resident needs within the home and community. The results of the Community Health Needs Assessment were then reviewed to help Adena establish innovative solutions to addressing needs within the home and the community for their ACO patient population. The data collected for the Community Health Needs Assessment was a result of primary data sources as well as secondary data sources. For the primary data source, the responses from community questionnaires were collected and analyzed (Partners for a Healthier Ross County, 2016). Additionally, aggregate focus group information around topics presented in the community questionnaire were also utilized to gain a deeper understanding into questionnaire results. Secondary data sources included publically available statistics around demographics, economic stability, as well as health outcomes and chronic disease prevalence (Partners for a Healthier Ross County, 2016).

Based on the Community Health Needs Assessment, it was concluded that 64% of the population residing in Ross County is between the ages of 18 and 64. Furthermore, 19% of individuals residing in Ross County currently live at or below 100% of the Federal Poverty Level (FPL) (Partners for a Healthier Ross County, 2016). The high rate of residents living at or below 100% of the FPL is similar to other regions of Appalachia (Partners for a Healthier Ross County, 2016). However, the population living at or below the FPL is 3% higher than that of the United States (Partners for a Healthier Ross County, 2016). In addition to economic challenges faced by the community, there are also significant educational and workforce challenges. Specifically, 16% of adults residing in Ross County have not graduated with a high school diploma, which is much higher than Ohio's average of 11.5% (Partners for a Healthier Ross County, 2016). Approximately 15% of the population residing in Ross County holds a bachelor's degree which is significantly lower than Ohio's average of 25.6% (Partners for a Healthier Ross County, 2016). Additionally, based on community surveys, 16% of residents believe that the community should focus on creating higher paying employment opportunities (Partners for a Healthier Ross County, 2016).

The Community Health Needs Assessment also focused on disease demographics for the population, concluding that the fourth leading cause of was Pulmonary-Respiratory Disease (Partners for a Healthier Ross County, 2016). In reference to disease demographics, the assessment examined health behaviors as well as environmental factors that impact the overall health of the community. Based on the analysis, the Community Health Needs Assessment concluded that tobacco use was an important health behavior to address, as smoking rates in Ross County are much higher than national averages (Partners for a Healthier Ross County, 2016). Furthermore, the assessment examined environmental factors that impact disease, mortality, and morbidity. The assessment concluded that the community experiences difficulty in getting basic needs met such as affordable housing, food security, and access to services (Partners for a Healthier Ross County, 2016). Health care access was also a significant environmental factor contributing to barriers experienced by residents of Ross County. Based on community survey results, 28.6% of residents indicated that co-payments were a barrier to care (Partners for a Healthier Ross County, 2016). Similarly, 17.8% indicated that they struggled to access health services due to difficulty in

taking time off work or the inability to leave work to see a physician (Partners for a Healthier Ross County, 2016).

Based on the results of the Community Health Needs Assessment, Adena decided to focus on impacting social determinants of health to achieve the Triple Aim outcome measures for their ACO population. In an effort to impact the patient across the care continuum, specifically in regards to social determinants, Adena sought to partner with National Church Residences, an innovative leader integrating health care and other supportive services for seniors, families, disabled populations and others who need them nationwide. National Church Residences currently utilizes a “stay-at-home” healthcare program called Home For Life, which focuses on keeping members in the community safe and healthy at home. Home For Life incorporates four elements; Enhanced Service Coordination, Care Guide Assessments, healthcare preferred provider partnerships, and socialization. The Enhanced Service Coordination model is a proactive, outcomes-based service model that focuses on impacting the social determinates of health by connecting seniors to appropriate services to address their needs. National Church Residences Enhanced Service Coordinators utilize an online assessment platform called Care Guide, which consists of evidence based assessments and evaluations to efficiently stratify residents, identify and meet the needs of each resident, as well as impact health and social outcomes. Care Guide aims to address social determinants of health but expands further to directly impact health outcomes such as unnecessary emergency room visits or medication access and adherence. The needs of the patient’s or community members are further met through partnerships or preferred provider agreements established with other agencies to provide needed services to program participants. Additionally, the program highly focuses on encouraging socialization through social interaction, participation in mild exercise, as well as mental stimulation in an effort to prevent health decline.

Although National Church Residences saw positive impacts on health outcomes as a result of the Home For Life program, the organization sought to work directly with a hospital and their patient population to access medical claims data in order to gather information and concrete evidence regarding the impact of Enhanced Service Coordination on addressing health outcomes. Similarly, Adena wanted to

partner with an agency that could impact patients of the ACO program within the community in order to meet the goals of the Triple Aim. Thus, the COPD Co-pilot program between Adena and National Church Residences was established. The objective of the pilot was to meet the Triple Aim goals by managing the health and tracking the outcomes of 100 severely vulnerable patients within Adena's ACO population. To accomplish the triple aim goals, National Church Residences Home For Life model was to be integrated into Adena's care delivery process. Upon completion of the pilot, the success and replicability of the Home For Life model within various health care delivery settings will be determined.

Program Design and Implementation

In 2015, Adena reached out to National Church Residences to learn more about their Home For Life model and the potential of the model to improve health outcomes and patient experience, while simultaneously reducing cost. Soon, discussions regarding a co-pilot between the two organizations began and after many discussions and various Inter-Disciplinary Meetings, a partnership was established January 1, 2016. Over the course of the next month, specifics regarding the co-pilot were solidified and the COPD Co-Pilot between Adena and National Church Residences was finalized. The COPD Co-Pilot was to integrate the Home For Life model into Adena's current care delivery process. The success of the program was to be determined by the program's ability to reduce the readmission rate to 17.6%, ensure continued patient satisfaction, while also reducing cost by 10% for Adena's most vulnerable COPD patients within the ACO. The two organizations also decided to examine the projects replicability amongst other disease demographics as well as various health care organizations.

As a part of the COPD Co-Pilot program, a new Enhanced Service Coordinator was to be hired and managed by National Church Residences. This Enhanced Service Coordinator was hired in February of 2016 and was tasked with implementing the Home For Life model amongst an established group of patients within Adena's ACO. In February of 2016, Adena targeted 201 patients within their ACO who had a primary diagnosis of COPD and who were identified as high risk. Adena determined high risk

COPD patients within the ACO by utilizing a risk management tool created by Conifer Health Solutions, an organization focused on helping health care providers support new payment models, such as a shared savings program, through care management optimization. Conifer's system allowed Adena to identify 201 patients that would benefit from increased care management based on the patient's current health outcomes, patterns of care, as well as financial spending.

In February of 2016, Adena sent letters to notify the 201 patients about the Home For Life program. In March of 2016, the Enhanced Service Coordinator began reaching out to the selected patients to discuss the Home For Life program. During this process, patients opted into the COPD Co-Pilot program. As a result, 100 patients out of the initial 201 patients designated as candidates for participation choose to participate in the COPD Co-pilot program. Once the program participants had been finalized the Enhanced Service Coordinator began making house visits. During these visits, the Enhanced Service Coordinator met the participant and their family, completed necessary assessments regarding social determinants of health and current health needs, as well as entered the information into Care Guide. Care guide is the online documentation platform utilized by National Church Residences to optimize outcomes. Assessments for all 100 patients were completed by August of 2016.

Upon completion of assessments, participants were further stratified into risk groups based on their score from the Vulnerable Elderly Survey (VES). The VES is a researched based survey utilized to assess a person's perception of health and mobility, as well as determine their risk of health deterioration (Saliba, 201). Those participants with a higher VES score were to be met with and monitored more often than their low VES score counterparts, as they were at a higher risk of experiencing health decline. The additional risk stratification allowed the Service Coordinator to better allocate resources and time to participants that were most desperately in need of assistance. As a result, the Service Coordinator began completing bi-weekly home visits or phone calls for high risk participants and monthly home visits or phone calls to low risk participants. During weekly or bi-weekly follow-up, the Service Coordinator completed assessments to effectively identify and address current care gaps and health needs.

Furthermore, when health declines were observed, the Service Coordinator would notify the nurse navigator so that the participant could receive the appropriate care. As a result, there was daily interaction between the Service Coordinator and the nurse navigator in order to discuss patient needs and care plans (see Appendix A for workflow diagram).

After the Service Coordinator had met with and collected enough information on the program participants in May 2016, Adena and National Church Residences began holding monthly Inter-Disciplinary Team Meetings (IDT) to review pilot progress, address barriers and concerns, as well as monitor and discuss outcomes. In order to track and review pilot progress and outcomes, Adena and National Church Residences began collecting and analyzing financial data as well as Care Guide assessment data in February of 2016. The data from Care Guide was reviewed in a monthly dashboard that outlined monthly visits and follow-up, community demographics, Activities of Daily Living (ADL) needs, patient reported chronic conditions, patient fall risk, care gaps, as well as admission rates. Adena's financial data was also reviewed in a dashboard outlining current and projected spending trends in comparison to previous financial data (see Appendix B for Dashboard example). Additionally, in May of 2016, the Service Coordinator began attending weekly meetings with National Church Residences Home Care team in order to stay up to date on the participants care and health needs. The Service Coordinator also began attending weekly meetings with the nurse navigator assigned to pilot participants in March of 2017.

As the year progressed, **the pilot began to show significant financial savings as well as significant progress towards reducing readmission rates.** As a result, discussions regarding the expansion and continuation of the pilot began in April of 2017 and are currently on going. The objective of these discussions is to establish an agreement to continue and expand the current COPD Co-pilot (see Appendix C for timeline graphic).

Data Analysis and Outcomes

In order to evaluate the outcomes and determine the success of the COPD Co-pilot, the information and data collected through medical claims data, electronic medical records, as well as Care Guide was analyzed and reviewed over the continuation of the pilot. As mentioned previously, success of the program was to be based on the Triple Aim goals of reducing cost by 10% and reducing the readmission rate to 17.6%, while also ensuring patient satisfaction with the COPD Co-pilot program.

The data was analyzed on a calendar year timeline as agreed upon by both organizations prior to finalization of the COPD Co-pilot agreement. It is important to note that other timelines for reviewing data were explored, such as starting the data review once all assessments were completed in August 2016 or reviewing the data on a rolling basis only for participants who had been assessed within a given month. All evaluation methods were thoroughly explored and both organizations determined that a calendar year timeline for data review was a better indicator of program success. Thus, the timeline for data review will span from January of 2016 to December of 2016.

Financials

In order to evaluate the program's impact on reducing cost, the total cost of care spent on the 100 participants was compared on a year to year basis. Thus, the total cost spent for Q1 2015 to Q4 2015 was compared to the total cost spent for Q1 2016 to Q4 2016. By examining **Figure 1** and **Figure 2**, it was concluded that the COPD Co-pilot program reduced the cost of care by 15%.

Figure 1 – Total spend by quarter for each calendar year with linear trend lines.

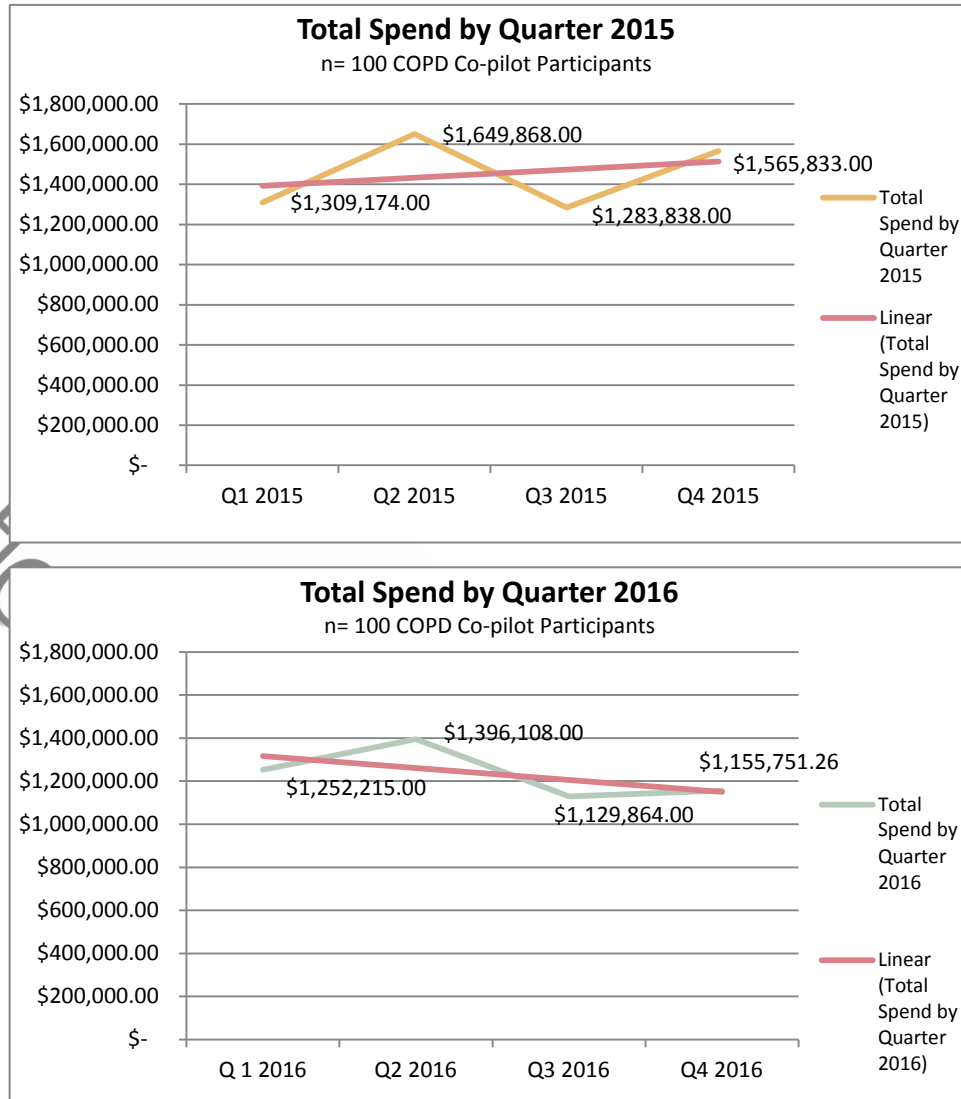
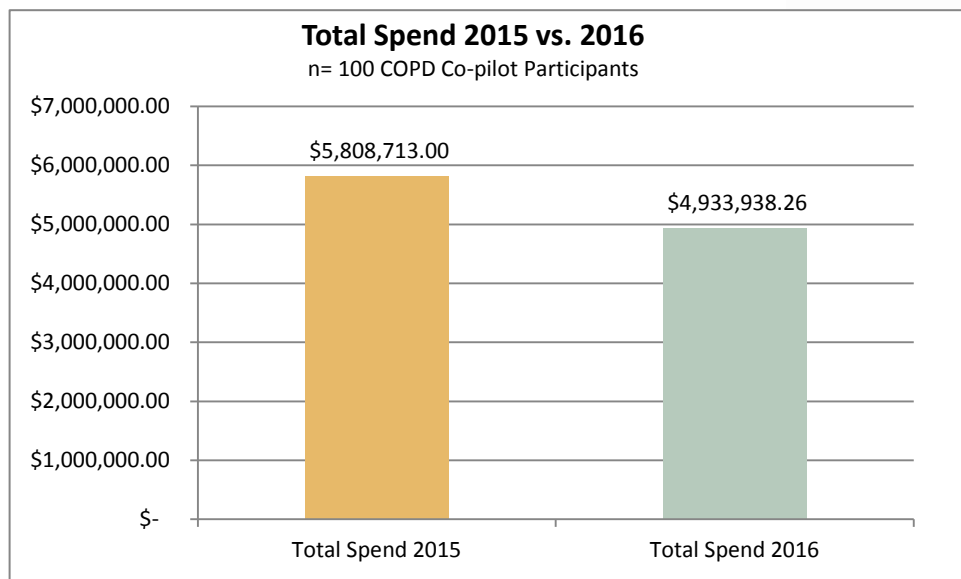


Figure 2 – Total spend by each calendar year for COPD Co-pilot participants

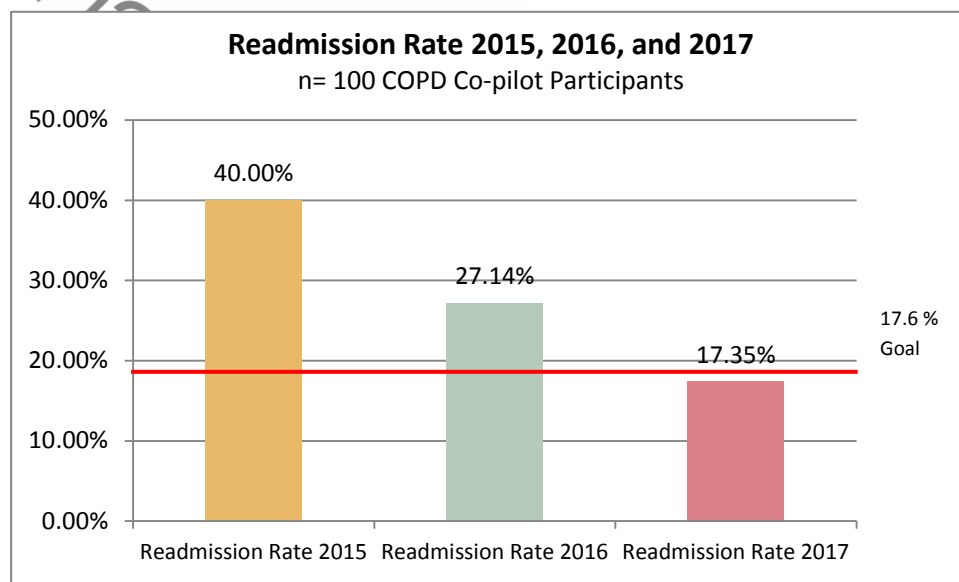


Readmission Rate

In order to determine the readmission rate for the COPD Co-pilot participant population, the total number of readmissions that occurred over one year was divided by the total number of admissions that occurred over one year. The readmission rate for 2015 was then compared to the readmission rate for 2016 and 2017. Based on this calculation method, or **Figure 3**, it was determined that the readmission rate for the COPD pilot decreased by 32.14% from 2015 to 2016 and 36.09% from 2016 to 2017.

Additionally, based on this calculation, the COPD Co-pilot readmission rate for 2017 was below the goal of 17.6%.

Figure 3 – Readmission Rate by calendar year. The Readmission Rate was calculated by determining the total # of readmissions/ total # of admissions that occurred over the year January 1, 2015 to December 31, 2015 versus January 1, 2016 to December 31, 2016 versus January 1, 2017 to December 31, 2017.



Patient Satisfaction

The evaluation method for patient satisfaction is currently being explored and reviewed. Nonetheless, it is likely that all remaining COPD Co-pilot participants will be asked to complete a patient satisfaction survey. It is important to note that a patient satisfaction survey was completed by a third party vendor. However, after extensive review of the question format as well as the data collection methods utilized in survey collection, it was concluded that the data gathered was compromised and would not be an accurate indicator of patient satisfaction. As a result, a new patient satisfaction survey will be completed by a different third party vendor in order to ensure unbiased, accurate results. The use of a different vendor for the survey, in addition to changing implementation guidelines, allows patient satisfaction to be appropriately and accurately analyzed.



National Church Residences

Secondary Data Analysis

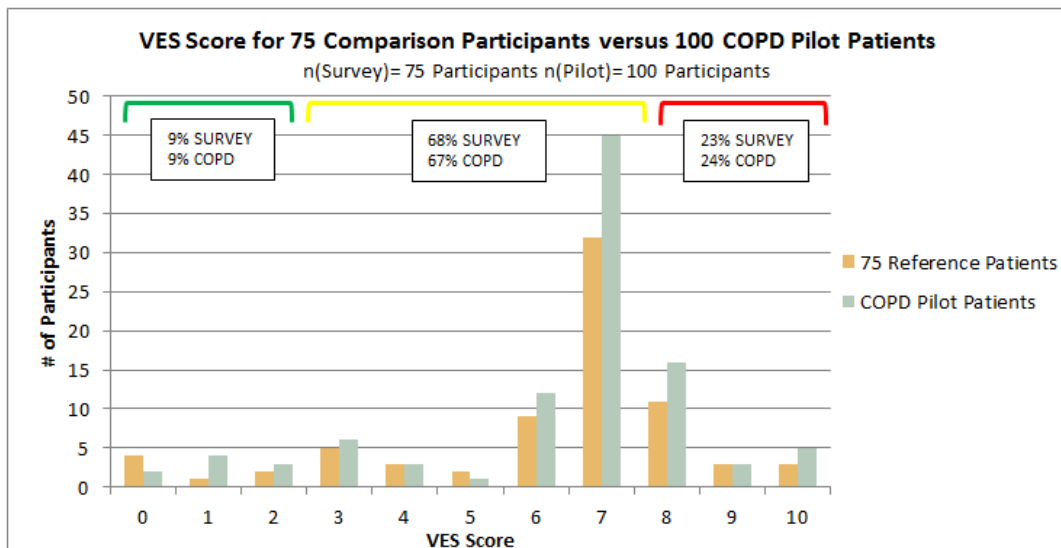
As discussed, the VES was utilized to stratify COPD Co-pilot participants to determine a participant's risk of health decline. In order to evaluate the effectiveness of the VES, a comparison study was conducted. Patients with comparable demographics to those participants in the COPD Co-pilot were contacted to take the VES Survey over the phone. Of those patients contact, 75 agreed to take the survey.

Table 1 and **Figure 5** review the results of the survey.

Table 1 – Table 1 outlines the results of the VES comparison study in reference to the results of the VES for the COPD Co-pilot participants.

VES	75 Comparison Participants (%)	COPD Pilot (%)	Vulnerability Category	Percent in Vulnerability Category	
				75 Comparison Participants (%)	COPD Pilot (%)
0	5%	2%	Low Vulnerability	9%	9%
1	1%	4%			
2	3%	3%			
3	6%	6%	Moderately Vulnerable	68%	67%
4	4%	3%			
5	3%	1%			
6	12%	12%			
7	43%	45%	Severely Vulnerable	23%	24%
8	15%	16%			
9	4%	3%			
10	4%	5%			

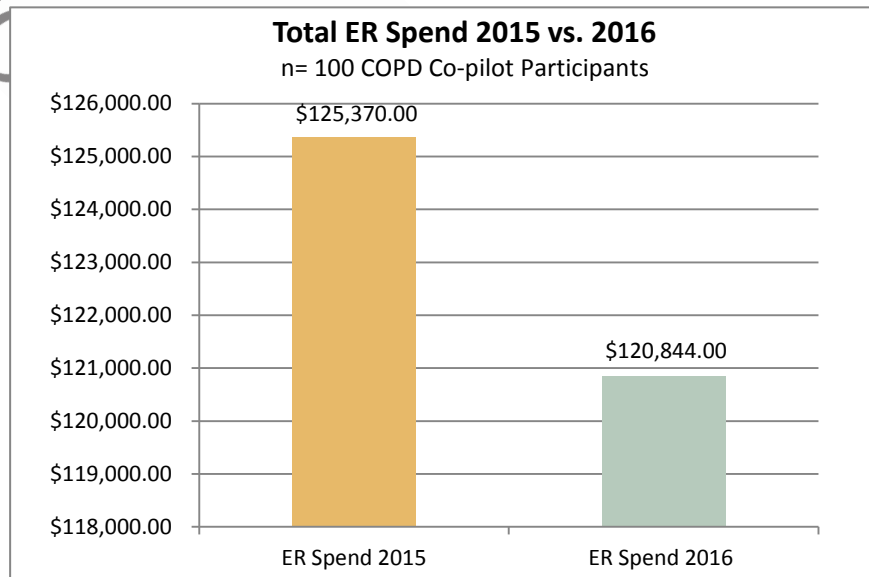
Figure 5 – Figure 5 outlines the results of the VES comparison study in reference to the results of the VES for the COPD Co-pilot participants.



Based on the survey, the comparison study yielded similar results to the initial VES Survey conducted amongst the COPD Co-pilot participants, validating the VES as an appropriate tool for risk stratification.

Additionally, emergency room (ER) visit spend was examined to determine whether or not there was a decrease in total ER spending from calendar year 2015 to 2016. Based on the results from **Figure 6**, it was determined that total ER spending decreased by 4%.

Figure 6 – Total ER spend by each calendar year for COPD Co-pilot participants



It is important to note that examining the reduction in unnecessary ER visits was also explored. However, due to current data limitations, the information to determine unnecessary ER visits was not available within the timeline of this pilot. As a result, it will be considered in the future. Additionally, measuring Quality of Life as an indicator of program success was also reviewed and ultimately not utilized. It is recognized that Quality of Life is important and, as a result, should be considered for future programs. However, it was not examined within this pilot as it was concluded that examining Quality of Life was beyond the scope of this specific project.

Discussion - Challenges, Limitations, and Future Considerations

Over the course of the COPD Co-pilot, both organizations recognized limitations that impacted or influenced pilot program logistics, data analysis, as well as outcome success measures. The challenges and limitations impacting the pilot have been reviewed within three broad categories; data and financial management, operations management, and communication management.

There were various barriers that impacted the data and financial management aspect of the COPD Co-pilot. Specifically, the amount paid to Adena from Centers for Medicare and Medicaid Services (CMS) for providing health care services was the financial data utilized to determine cost savings. Unfortunately, medical claims data from CMS experiences a lag time of five to six months. As a result, cost savings could not be completely calculated in the present and had to be calculated five to six months after services had been provided. Thus, it was difficult to measure pilot success and make appropriate program alterations in the present, as the data was not fully indicative of true financial outcomes and healthcare utilization. In order to address the lag time barrier, a financial dashboard was created and updated on a monthly basis. Although the data was not finalized in the present, the dashboard still provided important information on the pilot program. Based on the information in the dashboard, the team was able to make predictions on spending patterns and health care utilization by comparing the previous year spending for a given month to what had been spent within the current month. The use of the financial dashboard allowed the team to gain a better understanding of the outcomes occurring in the present regardless of the lag time limitations.

In addition to barriers in regards to accessing and analyzing financial data in the present, barriers were also experienced in pulling clinical data to ensure the pilot impacted the general health and well-being of all the program participants. The organizations experienced significant lag time in working with the vendor to pull and analyze clinical data points. As a result, aggregate clinical outcome data was not examined in real time but rather retrospectively as the pilot program came to completion. Moving forward

it is recommended that the team examine the analytical tools capabilities and establish data needs prior to program 'Go Live.' In addition to barriers, certain limitations impacted the data analysis. For example, patients had various primary care providers that were not affiliated with the Adena Health System. In order to examine clinical outcome data, the team looked through Electronic Health Records (EHR) to discuss care plans with the Enhanced Service Coordinator. When the patients had a different primary care provider, the team was not able to review the EHR and thus could not review health outcomes. It is recommended that going forward all program participants selected to participate have a primary care provider within the Adena Health System. Furthermore, some patients had multiple diagnoses and for some, COPD was not their primary diagnosis. It is recommended that going forward patients selected to participant in the program have a primary diagnosis of COPD in order safe guard data as well as ensure project integrity when examining the Triple Aim outcomes.

Over the course of the pilot the organizations recognized various limitations in the operations management aspects of the program that should be considered moving forward. When selecting program participants, it is recommended that patients be geo-zoned and excluded from the program if they do not reside within a certain geographic region. Additionally, it is suggested that the efficiency of the Enhanced Service Coordinator to patient ratio be reviewed and changed if proved to be a barrier in achieving success measures of the COPD pilot program. These recommendations are a result of limitations experienced by the Enhanced Service Coordinator when completing home visits for every patient every month. In the current program, patients are spread out amongst at 22 mile radius. As a result of this large range, the Enhanced Service Coordinator struggled to visit all 100 patients over the course of the month. Ensuring that the patients reside within a certain geographic area reduces travel time and allows the Enhanced Service Coordination to improve work flow efficiency. Additionally, home visits can range from an hour to a three or four hour visit depending on the patients' health status and current needs. Since the patients in the pilot were some of the most at risk or vulnerable patients, the Enhanced Service Coordinator spent a large amount of time on visits every month. The variable timing of visits, along with

the large number of vulnerable program participants, made it difficult for the Enhanced Service Coordinator to complete all assessments and referrals within the time frame expected. As a result, the Enhanced Service Coordinator began focusing on follow-up calls. The team quickly determined that follow-up calls, although helpful, left an important aspect out of the program; seeing the patient in their environment. As a result, moving forward, the Enhanced Service Coordinator should be required to complete all follow-ups with a Home Visit. Furthermore, geo-zoning patients as well as diversifying the patient vulnerability risk helps address limitations in the Enhanced Service Coordinator to patient ratio, ensuring maximized band width and program efficiency.

In considering limitations that impact Enhanced Service Coordinator bandwidth, the organizations explored the idea of graduation protocols or success measures. These success measures could be measures that indicate when a patient is succeeding in the program and effectively managing their health through their connectedness to needed social and healthcare services. It is recommended that this be considered in the future, as it would allow the program to enroll more patients as successful patient's transition out, maximizing the program's impact. Additionally, the graduation of patients from the program allows a support group to be established, where patients currently in the program can discuss barriers and challenges with patients who have successfully completed the program and are consistently utilizing appropriate social services and health care services.

Another limitation of the operations management piece of the program is how the patients were selected and stratified for participation. Prior to program 'Go Live,' both organizations had defined and determined stratification of patients using various methods. However, communication around these methods and implementation of these specific methods were not completed until after participants were selected. It is recommended that both methods for stratification, which include spend and health care utilization patterns from Adena Health System and the VES from National Church Residences, be used in the stratification process prior to program 'Go Live.' Additionally, all patients selected for the program were high risk based on Adena's risk stratification methods. As the program progressed, the team

proposed that finding a method for determining rising high risk patients should be a priority going forward. Identifying at risk patients is an important consideration as the organization's felt that the program may have the greatest impact in preventing health decline in this patient population rather the high risk patient population.

Furthermore, assessments and interventions were completed on a rolling basis from March of 2016 to the present. It is recommended that in the future, with new program participants, no interventions be completed until all assessments are completed. Completing all assessment prior to interventions allows the data to be collected utilizing a method that facilitates accurate data analysis in regards to determining program impact. Similarly, the teams hold monthly IDT meetings where the group can review barriers and challenges as well as successes. The content of the IDT meetings was not established until part way through the program 'Go Live.' It is suggested that the topics and measures reviewed at every IDT be established prior to program 'Go Live' to ensure maximum productivity of the group.

Finally, there were limitations and certain barriers to program success in regards to the communication management aspect of the COPD Co-pilot. Over the course of the pilot, multiple nurse navigators worked with the patient population. The utilization of multiple nurse navigators for pilot participants impacted the Enhanced Service Coordinators workflow. The nurse navigators assigned to a patient as well as which patients were currently being navigated changed often over the course of the pilot. The change in navigation proved challenging to the Enhanced Service Coordinator when it came to identifying whether or not the patient was currently navigated as well as which nurse navigator was working with the patient. Half way through the pilot, it was decided that there would be one nurse navigator for the program patients. Not only was there one nurse navigator for the patients but also the nurse navigator had specific experience in the clinical care of patients with COPD. This change improved communication barriers and the Enhanced Service Coordinator and nurse navigator began working together on a daily basis. As a result, it is proposed that one nurse navigator manage the patients at the onset of the program. Additionally, over the course of the pilot, weekly meetings with the nurse navigator

and Enhanced Service Coordinator were established in order to facilitate consistent communication around patient needs and hospitalization status. It is recommended that the weekly meeting as well as the content or information reviewed during the weekly meetings be established prior to program 'Go Live.' Similarly, the information reviewed during the monthly IDT meetings was not established until mid-way through the pilot program. Once metrics to be reviewed and information to be discussed were determined, communication and collaboration amongst the group during the monthly IDT meetings significantly improved. The standardization of information reviewed also improved the efficiency of the Monthly IDT meetings, ensuring that all appropriate topics were covered in the allotted time frame. As a result, it is also recommended that data points and program components to be discussed in the IDT meetings be finalized prior to the start of the program.

At the onset of the program, Adena Health System had an established physician lead as a reference when clinical barriers presented themselves. As the pilot progressed and clinical workflow issues were discovered, it became clear that a physician lead on both sides was imperative to establishing program goals as well as addressing program barriers and limitations. Moving forward, it is suggested that both organizations have an established physician lead. Finally, it is recommended that supervision of the Enhanced Service Coordinator occur locally. At the onset of the pilot, the Enhanced Service Coordinator's supervisor was not located within the Chillicothe region. As issues and barriers arose, in person communication between the supervisor and the enhanced service coordinator proved to be difficult. As a result, the supervision of the Enhanced Service Coordinator changed part way through the pilot program. This allowed for streamlined communication between the Enhanced Service Coordinator and the program supervisor. In addition, it is recommended that the supervisor also have a clinical background. When selecting a local supervisor, it was imperative that the supervisor have a clinical background in order to ensure an additional clinical perspective around the program and specific participant needs. This added clinical perspective ensured enhanced clinical support for the National Church Residence's team.

Conclusion – Moving Forward

Upon examining the COPD Co-pilot between Adena Health System and National Church Residences, it was determined that the pilot met two of the three established Triple Aim goals. Specifically, the COPD Co-pilot reduced cost by 15% and reduced the readmission rate by 32.14%, bringing the overall readmission rate for 2016 to 27.14%. Although the goal of a 17.6% readmission rate was not met for 2016, the reduction in the readmission rate by 32.14% is significant and as a result it was determined that the readmission rate goal was met. It is important to note that team did not meet the Triple Aim goals entirely in regards to patient satisfaction. The team is currently working through innovative solutions to establish patient satisfaction metrics that allow for appropriate outcome analysis. Discussions around COPD Co-pilot expansion are currently underway as it was concluded that the COPD Co-pilot program was successful and would include a more pronounced effort on patient satisfaction moving forward.

The initial COPD Co-pilot participants will continue to be in the program over the next five years in an effort to measure the programs long term success. As discussed, the program will grow to include additional lives, increasing the total number of participants. As the program expands, changes and alterations will occur as a result of the lessons learned over the course of the initial pilot program. Specifically, participants will be selected based on geographic location to ensure maximum efficiency within the Enhanced Service Coordinator's workflow. Additionally, the VES will be included as a factor in the risk stratification completed prior to program 'Go Live' in order to determine appropriate participants for the COPD Co-pilot. The VES will be included in the determination of participants because participants with a VES score of five or greater allow for optimized health care outcomes. An additional enhanced service coordinator will likely be hired and the management of the enhanced service coordinators will occur with a local supervisor in Chillicothe. Furthermore, prior to the 'Go Live' of the program's expansion, additional community partners will be established to more efficiently connect participants to appropriate community resources. Moving forward, in an effort to better align

organizational goals and quality outcomes, National Church Residences will also have a physician lead on the team. National Church Residences physician lead will work with Adena's physician lead to address potential clinical care barriers within the program. In conclusion, Adena Health System and National Church Residences are currently working to expand the COPD Co-pilot program. As the program continues to grow and evolve, both organizations hope to determine the pilot's replicability amongst patients with other disease demographics, such as Chronic Heart Failure. Moving forward, the organizations hope to demonstrate the programs marketability as a resource for effectively managing the health of America's sickest populations.



National Church Residences

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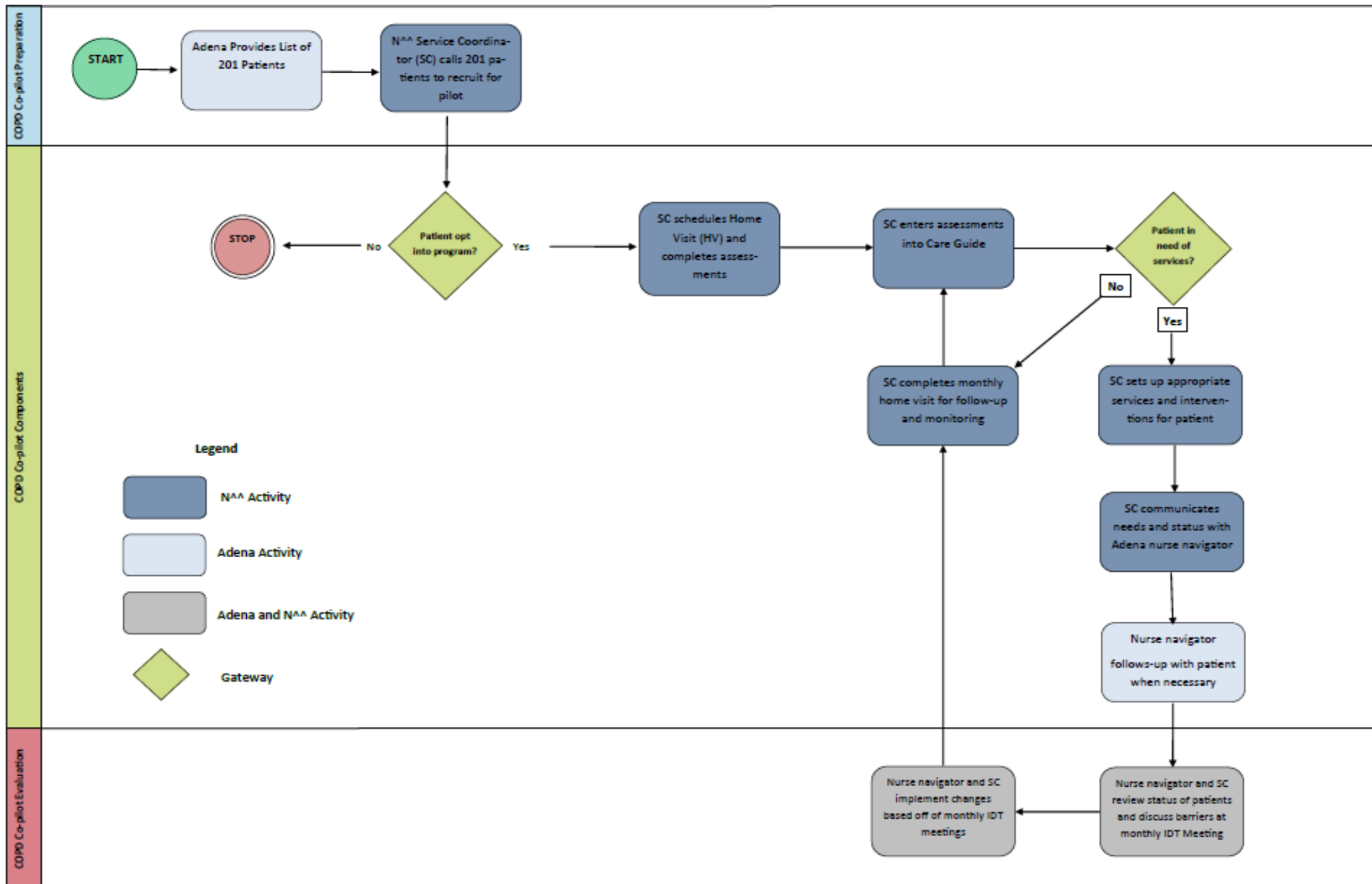
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National Church Residences



Appendix A

The following graphic is a diagram of the Enhanced Service Coordinator's workflow once integrated into Adena Health Systems care delivery process.



Appendix B

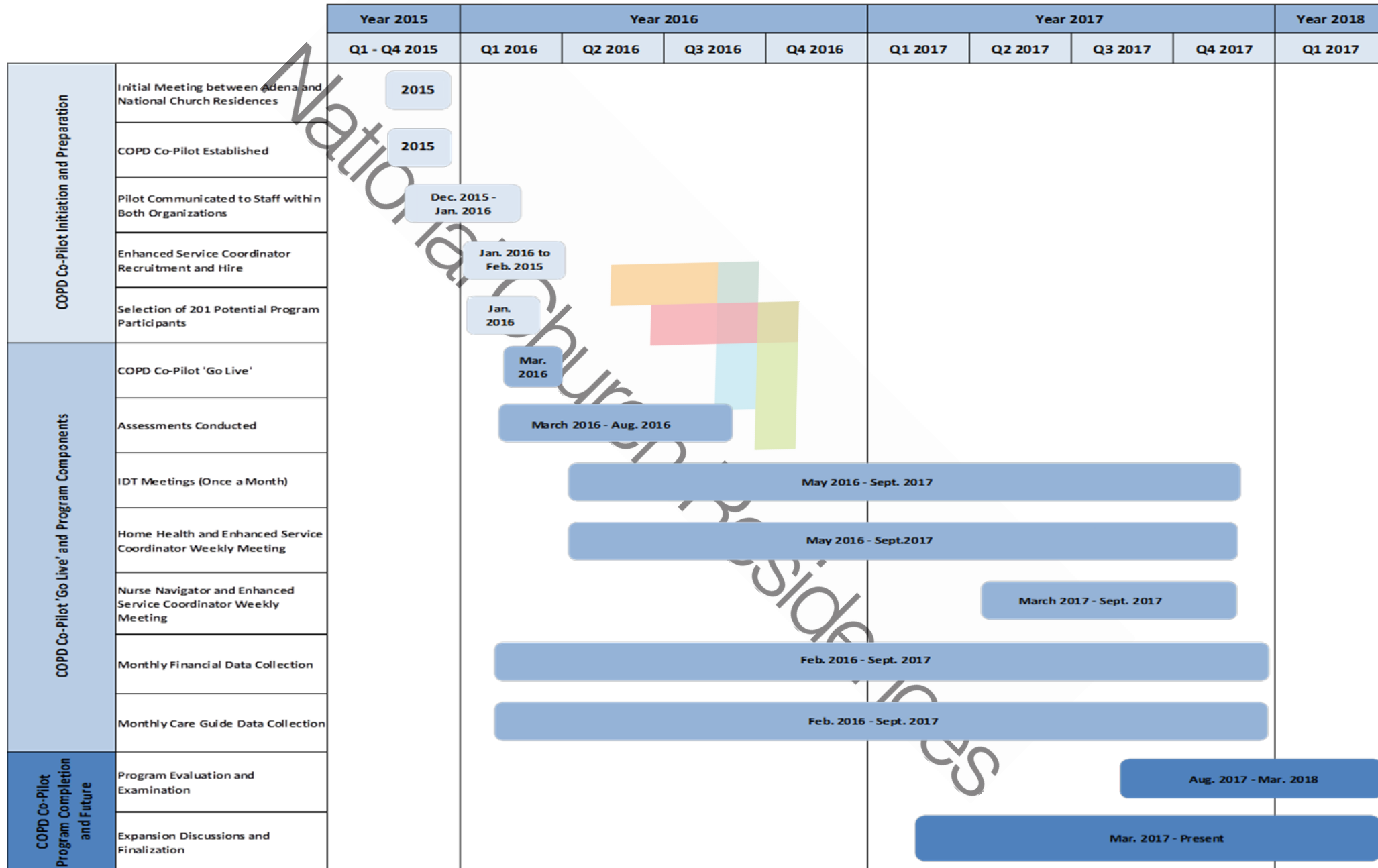
Example of financial and care guide dashboard used during IDT meetings. Please see dashboard provided.

National Church Residences



Appendix C

The following graphic is a timeline of the COPD Co-pilot program that outlines COPD Co-pilot Initiation and Preparation, COPD Co-pilot Program 'Go Live' and Program Components, as well as COPD Co-Pilot Program Completion and Future.



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