Optimizing Health and Function as We Age Roundtable Report

AHRQ
Agency for Healthcare
Research and Quality

Optimizing Health and Function as We Age Roundtable Report

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Introduction

Purpose

The **Optimizing Health and Functional Status as We Age Roundtable** was held on April 14, 2023, in Rockville, Maryland. Sponsored by the Agency for Healthcare Research and Quality (AHRQ), the Roundtable's purpose was to identify how AHRQ can have meaningful impact with respect to research, dissemination, and implementation of evidence to improve the organization and delivery of healthcare with the goal of optimizing the health, functional status, and well-being of the U.S. population as it ages.

Approximately 40 attendees from diverse healthcare, public health, social service, community-based, philanthropic, academic, and government organizations, along with patient and community representatives, contributed their expertise to the Roundtable.

Opening Remarks

Robert Otto Valdez, Ph.D., M.H.S.A., Director of AHRQ, welcomed participants to the Roundtable. He highlighted the extent to which aging is changing the composition of the U.S. population and the cultural shifts that have led to a more positive view of aging. Dr. Valdez challenged the Roundtable participants to think innovatively about how we can provide the medical care and other assistance that older adults require and how we should organize care delivery to be responsive to this population in which multiple chronic conditions and social needs are highly prevalent.

Dr. Valdez emphasized the challenges posed by our fragmented healthcare system and the difficulty of navigating it along with the burden this places on patients and families. This includes the problems encountered by many older adults with multiple clinicians who do not communicate with one another and who are unaware of the full breadth of care being provided to the individual patient. The lack of coordination among clinicians compounds the negative experiences that many patients have when encountering clinicians who have little understanding of their needs, desires, and quality of life.

Finally, he charged the Roundtable participants with considering where AHRQ should be heading in the future and how AHRQ can help healthcare systems and clinicians pivot to fully address the needs and desires of their patients regardless of the care setting.

Arlene Bierman, M.D., M.S., Chief Strategy Officer of AHRQ, thanked the planning committee and noted the overarching purpose of the Roundtable—to identify levers where AHRQ can have a meaningful impact through research, dissemination, and implementation to optimize health, function, and well-being in the aging population. She underscored the urgency of the challenge as the U.S. population aged 65 and older increased from 39.6 million in 2009 to 54.1 million in 2019 and is projected to reach 94.7 million in 2060.[1] This growth is occurring in the context of a healthcare system that is poorly designed and unprepared to meet the needs of this population. She highlighted the importance of preventing and managing multiple chronic conditions among midlife and older adults and of focusing on primary care, community settings, and care transitions. She also noted that the sustainability of Medicare and Medicaid depends on health system transformation to improve health outcomes among older adults.

Dr. Bierman highlighted the vital need for disruption and innovation in a system not designed to foster active, healthy aging and cross-sector collaboration. In a system where an estimated 25 percent of all spending is wasted,[2] opportunities exist to capture that funding to re-engineer healthcare delivery and create age-friendly ecosystems. She noted that slowing aging to increase life expectancy by 1 year would save $38 trillion, which would grow to $367 trillion[3] in 10 years. Therefore, the resources to transform healthcare to address this pressing problem could be made available with a sizeable, anticipated return on investment.

Improving health outcomes for older adults requires reimagining and strengthening primary care; integrating health, social care, and public health; increasing the focus on prevention and health promotion; connecting patients and families to community resources; and creating and maintaining strong partnerships with communities and cross-sector collaboration. Because low-income and minority individuals develop chronic conditions and functional limitations at earlier ages and members of these groups experience significant inequities in health and functional status, there is a vital opportunity to advance health equity by applying an equity lens to these solutions. These aims are aligned with the current U.S. Department of Health and Human Services priorities of strengthening primary care, addressing the social determinants of health (SDOH), and advancing health equity. Three recent National Academies of Sciences, Engineering, and Medicine reports,

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[1] Centers for Disease Control and Prevention. Promoting Health for Older Adults. Updated September 8, 2022. Available at: https://www.cdc.gov/chronicdisease/resources/publications/factsheets/promoting-health-for-older-adults.htm#:~:text=By%202040%2C%20the%20number%20of,diabetes%2C%20arthritis%2C%20and%20cancer.

[2] Shrank WH, Rogstad TL, Parek N. Waste in the US Health Care System Estimated Costs and Potential for Savings. JAMA. 2019;322(15):1501-1509. doi:10.1001/jama.2019.13978

[3] Scott AJ, Ellison M, Sinclair DA. The economic value of targeting aging. Nat Aging 1, 616–623 (2021). doi:10.1038/s43587-021-00080-0.

[Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care](#)[4]*; [Global Roadmap for](#)*
[Healthy Longevity](#)[5]*; and [Achieving Whole Health: A New Approach for Veterans and the Nation](#)*[6]*,* can provide
guidance on these efforts.

Finally, Dr. Bierman outlined the levers available for AHRQ to influence health outcomes for older
adults through its convening functions, which include developing learning communities; funding
health services research; using the Patient-Centered Outcomes Research Trust Fund to support
dissemination and implementation, clinical decision support, and training; providing tools and
resources for practice improvement and research; and using data and analytics.

Alice Bonner, Ph.D., R.N., Senior Advisor for Aging, Institute for Healthcare Improvement,
introduced herself as the facilitator and described plans for the day. These included sessions to
explore how to foster aging well and how to prevent and manage multiple chronic conditions with a
focus on primary care and ambulatory settings: a blue-sky discussion of what the ideal system would
look like; hearing person and community voices; hearing clinician, practice, and health system voices;
and exploring opportunities for integration with public health, social care, and other sectors to
address SDOH. The day also included breakout sessions focused on four topics:

- Developing and implementing models of care to foster aging well
- Developing partnerships with communities, public health, and social care
- Generating evidence on what works to transform care
- Scaling and spreading effective models and approaches

Pre-Meeting Survey

Before the meeting, participants were asked to complete an online survey. The survey consisted of a
series of questions designed to help participants and organizers to prepare for Roundtable
discussions. Participants all had substantial experience working to improve health and well-being
and/or fostering health equity as people age, as well as experience with approaches and
interventions to improve care delivery.

Designed by Adam Seth Levine, Ph.D., from Johns Hopkins University, the survey first asked
participants to describe the primary perspective(s) they represent (e.g., advocacy organization,
clinician, health system, community organization, public health) and the region of the country in
which they live.[7] They were then asked about 1) what interventions and approaches worked well as
well as challenges and barriers encountered in their implementation, 2) experiences with and need

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[4] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing high-quality primary care: Rebuilding
the foundation of health care. Washington, DC: The National Academies Press. doi:10.17226/25983.

[5] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing high-quality primary care: Rebuilding
the foundation of health care. Washington, DC: The National Academies Press. doi:10.17226/25983.

[6] National Academies of Sciences, Engineering, and Medicine. 2023. Achieving whole health: A new approach for
veterans and the nation. Washington, DC: The National Academies Press. doi:10.17226/26854.

[7] Levine, Adam Seth. "Unmet Desire." Issues in Science and Technology 38, no. 3 (Spring 2022): 27–31.

for informal collaboration (oriented toward knowledge exchange) to achieve objectives, 3) experiences with and need for formal collaboration (oriented toward projects or goals that entail shared ownership, decision-making authority, and accountability) to achieve objectives, and 4) roles AHRQ could play in advancing this work through dissemination and implementation initiatives, research opportunities, or convening stakeholders.

Participants provided examples of many successful models and interventions for improving care delivery for older adults. Common themes included the use of multidisciplinary teams; health system adoption of the 4Ms (what matters, medication, mentation, and mobility) highlighting the importance of identifying what matters most to patients and caregivers; caregiver engagement and support; and integrating primary care and geriatric care, behavioral health, and social care. The need for leadership, champions, evidence development, and advocacy were frequently mentioned. Despite many examples of effective approaches, barriers to sustainable interventions, and wide-scale adoption are numerous, including: non-aligned financial incentives, difficulty getting aging on the agenda as a priority, insufficient workforce and skills, inattention to caregivers, competing priorities, a fragmented system, and lack of whole person focus.

Participants also reported many examples of successful formal and informal collaborations, including community partnerships, cross-government collaborations, linkages to social care and public health, interdisciplinary partnerships, and caregiver engagement. Also highlighted was the role of training programs, especially those funded by the Health Resources and Services Administration (HRSA); foundation support, and professional societies. Specific examples mentioned included Area Agencies on Aging, The Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities, The Veterans Administration's (VA's) Whole Health program, and the Moving Forward Coalition.

Future need for collaboration across care settings, and multi-sector and multi-disciplinary collaborations was noted. These collaborations could advance innovation, education, research, and dissemination and uptake of clinical and community resources.

Opportunities

Throughout the day, Roundtable participants identified opportunities to improve the health and well-being of older adults and the challenges involved. Three main areas of consideration surfaced during the conversation and are discussed in the remainder of this report:

- Developing a truly person-centered care system based in primary care, including an enhanced focus on prevention and health promotion with strong linkages between clinical care, public health, and social and community services.
- Generating evidence on what works to transform care.
- Broadening impact.

Developing a Truly Person-Centered Care System

Realizing the Promise of Person-Centered Care
Throughout the day, Roundtable members highlighted the need to proactively put individuals, their families, and their caregivers at the center of the healthcare system, with a consistent focus on identifying their needs, goals, and preferences and implementing plans of care to help address their needs and achieve their goals. During discussion, members emphasized the need to understand how people learn about and access benefits and services. One participant noted the importance of modeling the ideal care journey in order to identify gaps in the current healthcare system as well as to address inequities in access to services. Another suggested that framing person-centered care as a human right could help to ensure that people consistently receive such person-centered care, and that the healthcare system prioritizes their needs:

> The Inter-American Convention on the Human Rights of Older Persons actually recognizes the human right to integrated person-centered care. It obligates state parties in that region to promote the development of specialized integrated social and healthcare services for older persons with diseases that generate dependency… There is not a comparable international convention that similarly obligates the United States.[8]

Focusing on an Individual's Health Goals and Priorities
Roundtable members noted the importance of realigning the goals of clinical care away from the current focus on adherence to prespecified targets and toward emphasizing goals that patients prioritize. A participant noted the following:

> The definition of success may not be cost savings, but that we're spending the money in the right place. We don't want to necessarily spend it on a hospital readmission. We might rather spend it on the services that allow people to stay in their homes, where they overwhelmingly prefer to be, and support them to maintain their health and function.

Such realignment could result in spending on and reimbursing social services and/or addressing health-related social needs, thus avoiding significant healthcare costs and better meeting patients' needs, as one participant described. Several members also emphasized the importance of going beyond identifying and providing recommended clinical services in the Centers for Medicare & Medicaid Services Annual Wellness Visit, to use the opportunity to elicit and understand the individual person's goals and desires.

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[8] Pan American Health Organization. The Inter-American Convention on Protecting the Human Rights of Older Persons as a tool to promote the Decade of Healthy Aging. Washington, D.C.: PAHO; 2023. Available from: doi:10.37774/9789275126943.

The concept of "whole health" as a way of focusing on patients' health goals and putting the patient at the center of the healthcare system and other services was mentioned several times during the Roundtable. Whole health is physical, behavioral, spiritual, and socioeconomic well-being as defined by individuals, families, and communities. Whole healthcare is an interprofessional, team-based approach anchored in trusted longitudinal relationships to promote resilience, prevent disease, and restore health that aligns with a person's life mission, aspiration, and purpose.[9] Participants highlighted a recent report from the National Academies of Sciences, Engineering, and Medicine on this topic and noted an opportunity to support research on what would be required to shift to whole-person care for older adults in the United States. Achieving whole health will require a multi-sector and whole-of-government approach.

Integrating the Voices of Older Adults, Care Givers and Communities

Roundtable participants emphasized the importance of including the voice of older adults and their caregivers as an integral part of the team designing any new models or programs to ensure that care is person-centered and equitable. This effort would include ongoing engagement of patient and family advisory councils in efforts to redesign care, improve care delivery and experiences with care. The importance of the patient voice as being "the idea of instead of what's the matter **with** me, it's what matters **to** me" was underscored. Thus, it is important to incorporate the voices of older adults in the clinical encounter and care planning as well as in practice and health system redesign.

Designing Effective Models of Care

Roundtable participants communicated that there are many evidence-based models of care that have demonstrated the ability to improve health outcomes as well as to address health inequities among older adults, including for example CAPABLE[10] a home-based program that provided services and supports needed to optimize functional status to enable community living, including interventions such as home modifications; GRACE[11] that provides expertise, training, and support to primary care practices to improve quality and outcomes of care for low-income elders; and PACE[12] that provides comprehensive care to nursing home-eligible adults to allow them to remain in the community.. The Hartford Foundation through its AGE-Friendly Health System initiative is supporting the implementation of the 4M principles to improve the care of older adults nationally. The challenge has been multiple barriers to scale and spread of these models, including misaligned payment incentives and workforce limitations.

Effective models of care to optimize health and function with aging while reducing health inequities require comprehensive shared care planning to identify patient priorities and goals and to develop a care plan that minimizes burden on patients and caregivers while supporting them in achieving these

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[9] National Academies of Sciences, Engineering, and Medicine. 2023. Achieving whole health: A new approach for veterans and the nation. Washington, DC: The National Academies Press. https://doi.org/10.17226/26854.

[10] Community Aging in Place | CAPABLE | School of Nursing at Johns Hopkins University (jhu.edu)

[11] https://archive.ahrq.gov/workingforquality/priorities-in-action/index.html#grace

[12] Program of All-Inclusive Care for the Elderly (PACE) | CMS

goals.[13] The U.S. Department of Health and Human Services has developed a definition of a comprehensive shared care plan as one that gives the person direct access to health data; puts the person's goals at the center of decision-making; is holistic, including clinical and nonclinical data (e.g., home- and community-based and social determinants needs and services); follows the person through both high-need episodes (i.e., acute illness) and periods of health improvement and maintenance; and allows care team coordination. The Care Team should be able to view information relevant to their role, identify which clinician is doing what, and update other members of an interdisciplinary team. Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.[14]

Informed by prior work and experiences, Roundtable members articulated factors, principles, and frameworks that can support the design of models and programs to support the health and well-being of older adults. These included the following:

- Becoming an Age-Friendly Health System (AFHS) entails reliably providing a set of four evidence-based elements of high-quality care, known collectively as the 4Ms, to all older adults in a healthcare setting or system. When implemented as a set, the 4Ms represent a broad shift by health systems to focus on the needs and evidence-based care of older adults.
- Ensuring age-friendly systems that include patient and caregiver voices
  - Ensuring that patient and caregiver voices are actively involved in the design of programs and are included in an ongoing advisory capacity throughout implementation
  - Adopting the 4Ms, a framework for age-friendly health care[15] : what matters, medication, mentation, and mobility
  - Using design thinking and rapid innovation approaches rather than having researchers design static interventions without community input
- Building connections to community resources
  - Embedding social workers, care managers, behavioral health clinicians, and others within primary care clinics
  - Enhancing connections between clinical practices and community resources
  - Developing effective partnerships and mechanisms for referring patients with SDoH needs to home and community-based services
  - Regularly convening organizations involved in care delivery to learn from one another and understand patients' needs
- Creating financial flexibility

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[13] U.S. Department of Health and Human Services 2015 Stakeholder Panel | Baker, et al. Making the Comprehensive Shared Care Plan a Reality. *NEJM Catalyst*. 2016: https://catalyst.nejm.org/making-the-comprehensive-shared-care-plan-a-reality/

[14] Care Coordination. Content last reviewed August 2018. Agency for Healthcare Research and Quality, Rockville, MD.

[15] Fulmer T. Discovering the 4Ms: A Framework for Creating Age-Friendly Health Systems. 2018: New York, NY. Discovering the 4Ms: A Framework for Creating Age-Friendly Health Systems (johnahartford.org)

o   Creating flexibility in what can be covered through payment design and/or having organizations assume full financial risk for a patient population (through value-based care or value-based insurance design)

Supporting Older Adults

Throughout the day, Roundtable participants articulated important roles that can support older adults' health and well-being and issues relevant to them depending on their needs and functional status. There was much discussion about the roles and needs of family caregivers and the importance of their input in program/model planning to ensure that their experience and needs are considered. The RAISE Family Caregivers Act defines family caregivers as family members or other individuals who have a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation.[16] Paid caregivers, including home health workers, direct care workers, certified nursing assistants, home health aides, and others also play a critical role. To address workforce shortages, Roundtable participants emphasized the need to create career ladders to provide growth opportunities and incentive.

Care navigators, peer advocates, and community health workers have all been employed to help older adults receive needed care, services, and supports. Peer advocates have been successfully used in programs within the Department of Veterans Affairs and have the potential to be useful in other programs. A community health worker is a trusted member of and/or has a close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health, social services, and public health and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Behavioral Health

Roundtable participants noted three key challenges regarding behavioral health for older adults, all of which are rooted in the fragmentation of the healthcare system.

First, they highlighted the need to integrate behavioral health into primary care. Members noted that the Collaborative Care Model could provide a good return on investment and could be a model for caring for older adults. This model embeds behavioral health professionals in practices with trained primary care providers and offers additional support for these providers through regular psychiatric case consultations. The focus is on providing evidence-based medication and psychosocial treatments for common mental health conditions such as depression and anxiety. However, this model has been exceedingly difficult to scale, and barriers to adoption need to be addressed.

Second, participants noted the need to expand the availability and use of electronic health records and digital solutions in behavioral health and described the extensive fragmentation of care that

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[16] [2022 National Strategy to Support Family Caregivers (acl.gov)](acl.gov)

particularly affects behavioral healthcare for older adults. This issue is described in greater detail in the "Data and Metrics" section below.

Third, participants described the importance of supporting the behavioral health workforce, with a need to invest in and provide leadership to clinicians, including the many psychologists and social workers, who do not work in large healthcare systems.

Meeting the Full Range of Needs: Social Determinants of Health

Participants broadly agreed on the importance of screening in clinical settings for challenges that older adult patients may be experiencing with SDoH, including housing, food, and transportation needs as well as available supports for caregiver's needs. They also underscored the important role of public health. Several contributors noted, however, that there is a large gap between the ability to conduct screening in a clinical setting and the ability to act on the information obtained from the screening. They pointed out that clinicians often need help knowing what to do with information from these screenings and are unaware of how or where their patients can access the resources they need. Furthermore, when referrals are made, capacity to address these needs in the community may be limited, for example, due to long wait lists for subsidized housing.

As the facilitator summarized:

> Clinicians … want to do the right thing, but they don't necessarily know how. They either don't have the skills or they don't have the resources. They don't know how to make those connections.

One participant from a large healthcare system discussed its approach to fully integrating social workers and SDoH screening with clinical care. By building social work partnerships at every level of the organization and mandating that a member of the social work team addresses concerns identified during SDoH screening, the organization has created close links between the medical and social work teams that benefit patients, caregivers, and clinicians. However, financial constraints (e.g., lack of reimbursement for services) and getting buy-in from hospitals in the system have posed challenges to implementing this model.

Opportunities exist to identify additional models that integrate health and social care and to develop feasible approaches to addressing SDoH concerns in clinical settings, including partnerships with Community Hubs,[17] Community-Based Organizations (CBOs), and social services providers, such as Area Agencies on Aging. To maximize the potential of these approaches, AHRQ could consider supporting research to understand what drives the success of existing models, what would be needed for their scale and spread, and what payment models might be best suited to funding these services.

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[17] Chappel A, Cronin K, Kulinski K, et al. Improving Health And Well-Being Through Community Care Hubs. Health Affairs Forefront. 2022. doi:10.1377/forefront.20221123.577877.

Partnerships with Community and Social Service Organizations and Public Health to Address Social Needs

The Roundtable discussions included strategies to address the social needs of older adults through health system partnerships with community and social service organizations. Participants identified the opportunity for Federal and State agencies to come together to encourage these partnerships and to identify what steps could be taken to promote effective collaboration.

Members noted that most clinicians, healthcare systems, and public health agencies are unfamiliar with the extensive aging services sector, including Area Agencies on Aging supported by the [Administration for Community Living](#) (ACL), posing a barrier to effective collaboration. Participants also pointed out that even in well-intentioned partnerships, implementing referral mechanisms that effectively address the non-clinical needs of older adults is challenging for multiple reasons, including financing and capacity. Finally, participants discussed the examples of healthcare systems addressing social needs and the importance of ensuring collaboration and partnership with existing community-based services.

Members suggested considering a wide variety of organizations and State and local agencies to include in partnerships designed to address the full range of health and well-being needs of older adults. These CBOs include parks and recreation departments, arts organizations, universities (including intergenerational learning programs), faith-based organizations, senior centers, Area Agencies on Aging, local Councils on Aging, and organizations that serve specific racial/ethnic groups, in addition to traditional disease focused-organizations (e.g., Alzheimer's associations, cancer associations). Participants emphasized the importance of looking beyond the "usual suspects" when considering organizations that might be productive partners.

Members also identified the potential of community hubs for coordinated care by providing a coordinating body for multiple social and community organizations who often work independently, now active in a growing number of communities. Hubs may serve as contractor to a Medicare Advantage plan or a health system and provide access through them to organizations offering a broad range of social services. One participant commented that two common services that community hubs provide under contract to health plans and health systems are care coordination and SDoH assessments and referrals. This individual noted that approximately half of the community hubs they surveyed that have at least one contract with a healthcare provider or payer are assessing and referring patients for SDoH needs.

Noted challenges to productive partnerships included funding levels and the separate funding streams that support different potential partners (particularly the distinct insurance reimbursement system for healthcare and grant-based funding for community organizations); lack of leadership for such partnerships; and lack of buy-in toward common goals. Efforts are underway to facilitate braiding and blending of different funding streams to better deliver and coordinate services. In

discussing approaches to address these challenges, Roundtable members emphasized the importance of good communication, sharing stories, and ensuring that partners engage in succession planning so that their efforts will survive if the original leaders leave their organizations. Members also highlighted the need to convene CBOs regularly to continue to learn from one another's experiences and to identify successful approaches to partnerships and service delivery for older adults.

The public health sector's focus on prevention has had a profound impact on longevity in the United States, and yet, historically and pre-pandemic, public health has not embraced efforts to improve the health and well-being of older adults. As the demographics of our population continue to shift, public health has the opportunity to elevate healthy aging as a core public health function, with a foundational focus on equity. To facilitate this transformation, Trust for America's Health, in partnership with The John A. Hartford Foundation, developed the Framework for Creating Age-Friendly Public Health Systems that includes the following activities:

- Creating and leading policy, systems, and environmental changes to improve older adult health and well-being
- Connecting and convening multi-sector stakeholders to address the health and social needs of older adults through collective impact approaches focused on the SDoH
- Coordinating existing supports and services to help older adults, families, and caregivers navigate and access services and supports, avoid duplication, and promote an integrated system of care
- Collecting, analyzing, and translating relevant and robust data on older adults to identify the needs and assets of a community and inform the development of interventions through community-wide assessment

Together, these conversations highlighted opportunities for AHRQ to support research that identifies evidence-based approaches to developing successful partnerships between healthcare systems, social service and community organizations, and public health with the ability to serve older adults.

Generating Evidence on What Works to Transform Care

Need for Data and Meaningful Metrics

Roundtable participants discussed a number of challenges to capture data and convert such data into meaningful metrics and accurate, timely, actionable, and nonjudgmental feedback loops to guide effective implementation in the context of a learning health system. Absence of these feedback loops and meaningful metrics pose barriers to creating more integrated care systems for older adults and proactively identifying older adults who face increased risks to their health and well-being.

First, significant lags in data timeliness impair the ability of programs to identify patients in need and deliver services promptly. As one participant noted:

Medicare doesn't know what services someone received until three to six months later when they actually get the claims data, which makes it really impractical if you have care coordinators … [who] don't know what happened until six months later. It's similar with Medicare Advantage plans. So, if there's a way to actually help to connect our healthcare system [to reduce data lags], that would really dramatically improve a lot of different things.

Second, many clinicians, healthcare organizations, and social service organizations were omitted from the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. These included behavioral health practitioners (psychologists, counselors, and social workers), nursing homes and assisted living facilities, and community and social service organizations.

As a result, many clinicians and organizations that provide services to older adults do not have access to electronic health records and have information systems that are not interoperable with systems in use by other clinicians and healthcare organizations. These issues limit clinicians' and organizations' access to information about individual older adults they may serve or who may need their services, and constrain the ability to communicate efficiently across organizations. Such challenges also affect clinicians working in different health systems with electronic health records that are not connected to one another.

Third, panelists noted that while healthcare quality measures and measures of patient experience are available to assess care delivery, such measures do not always assess what is truly meaningful to older adults. Panelists emphasized the importance of defining what is meaningful, collecting those data, and using them as the accurate, timely, actionable, nonjudgmental feedback loops to determine the impact of the care and services provided to this population in their local context and local community. The need for a parsimonious group of harmonized and widely adopted quality measures was emphasized, as was the potential for eCQMs (electronic clinical quality measures) to reduce burden. One participant suggested that healthy days lived at home (as opposed to in a hospital or other institution) could be one such relevant measure; others discussed the need to have measures of physical and cognitive functioning tracked in electronic health records.

The field would benefit from increased opportunities for research that addresses ways collect and use person-centered data, increase electronic information exchange with providers not covered by the HITECH Act, and identify meaningful measures that address what is most important to older adults.

Study Design and Research Methods to Generate Evidence for Transformation

Roundtable members discussed the challenges of exclusively relying on traditional randomized controlled trials (RCTs) when assessing health system changes and program effectiveness as well as

to foster innovation and rapid-cycle learning. They encouraged thinking about a broad range of study designs and research methods better suited to understanding what works to transform healthcare. The conversations included approaches such as the following:

- Small-scale A/B testing of nudge-based programs
- Engineering-based approaches that start with a definition of the standard for success and then set up a control chart and use a variety of approaches to meet the standard for success (as opposed to traditional research that defines a standardized intervention in advance)
- Development and testing of minimal viable products
- Agile implementation which includes 1) Agile Innovation to design human-centered strategies, processes, and tools; 2) Agile Implementation to implement them into routine care; and 3) Agile Diffusion to subsequently diffuse them across the various complex adaptive healthcare delivery human networks
- Approaches from complexity science
- Rapid-cycle evaluation
- Just-in-time adaptive interventions
- Ecological momentary assessment to impact behavior change, where randomization occurs immediately before a particular piece of data is gathered rather than randomizing individuals to different arms of a trial

As an example of new and emerging methods, agile science offers new approaches to design, implement, and diffuse scalable, evidence-based, and locally sensitive solutions targeting older patients and their healthcare providers. Agile science integrates insights from behavioral economics, complexity science, and network science to understand, predict, and nudge the behaviors of both an individual human and a social organization. Concepts from agile science, when applied to healthcare, allow us to understand healthcare delivery systems as complex adaptive networks, made up of semi-autonomous but interdependent humans who are connected to one another through a series of links and "neighborhoods" that inform with whom they interact and how frequently. Optimizing health and function as we age requires thinking at a system level, considering the local resources, processes of care, and relationships, as these all shape how care is organized and delivered. Agile science provides an approach to address the gap between what we know we should do based on evidence, and what we actually do in daily practice. The steps for employing the Agile Implementation Process in health system transformation are discussed in the next section.[18,19]

The group also outlined a general approach to research in support of the health and well-being of older adults:

- Develop clear methods for problem definition

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[18] Mehta J, Aalsma MC, O'Brien A, et al. Becoming an Agile Change Conductor. Front Public Health. 2022 Dec 14;10:1044702. doi: 10.3389/fpubh.2022.1044702;

[19] Lindroth H, Schumaker C, Taylor B, Boustani Z, Boustani M. Agile Mentorship: A Longitudinal Exploratory Analysis. ATS Scholar. https://doi.org/10.34197/ats-scholar.2022-0035PS

- Set goals with defined metrics that matter to older adults
- Identify where targeted solutions are needed to improve performance on those metrics
- Co-develop a targeted solution in those areas jointly with the community
- Evaluate the effort
- Develop approaches to generating real-world evidence as a program is in progress and address the barriers to the broad acceptance of such evidence as valid and reliable
- Develop a classification system for the reliable description of different types of interventions/programs
- Drive measurement approaches that are scalable and sustainable for use as programs are scaled and spread
- When assessing grant applications, encourage study sections to require the measurement of outcomes that matter to older adults
- Rank the impact potential of any solution based on its impact equation. The impact equation for any solution is the product of its effects size multiplied by its implementability, scalability, and sustainability
- Advance research by developing and promulgating a better understanding of the circumstances under observational studies provide critical evidence not otherwise available; and by defining standards for high-quality observational studies

Align Research Approaches with Health System Leaders' Needs

To support the adoption of innovative models and programs for improving the health and well-being of older adults, Roundtable participants emphasized the importance of approaching health system leaders to get support for proposed interventions and studies. Participants emphasized the need to focus on partnerships, align interests between the researchers and health systems, and communicate the need for and value of research-based interventions.

The steps outlined by the Agile Implementation Process provide one model for achieving these goals:

Step 1: Evaluate and Monitor Demand. The first step of the process is to identify and confirm the presence of an opportunity. While often overlooked, establishing sufficient demand within the organization is essential to ensure that sufficient time, staff, and resources will be allocated to the implementation and refinement of the solution. To identify opportunities, the scientist proactively works with leadership and clinical providers to understand the needs and goals of the organization. Sufficient demand is demonstrated when executive leadership and frontline clinical providers agree to allow or provide for the resources necessary to pursue the opportunity.

Step 2: Find Evidence-Based Solution. After identifying an opportunity and establishing demand within the organization, the next step is to identify the appropriate evidence-based solution. The most common sources for identifying these solutions are published literature and practice guidelines

or recommendations by industry specialists or policy makers. If no evidence-based solution exists, one should consider using Agile Innovation to create it.

Step 3: Develop Evaluation and Termination Plan. Prior to beginning the implementation, it is necessary to develop detailed plans for how the solution will be tracked and evaluated in the local setting. This includes plans for determining when a solution should be terminated, by whom, and based on what criteria. These plans require that the scientist fully understands the implications of the proposed solution on every level of the healthcare delivery organization, as well as the potential for external ramifications. Therefore, the scientist needs to have a solid grasp of both the solution and the organization (or needs to partner with someone who does) in order to conceptualize how members of the healthcare delivery organization will react and incorporate the solution within the current organizational hierarchy. This process also involves identifying reliable and valid measures that are feasible and allow for timely feedback to frontline providers on both the success of the solution for the intended target, but also on unintended and unexpected consequences or benefits. Some measure of the financial impact is also necessary, since the fiscal implications of the solution will determine its long-term sustainability.

Step 4: Localize a Minimally Viable Prototype. Together with the scientist, a selected group of key members within the healthcare delivery organization meet in this step to convert the evidence-based solution to the local setting. This conversion eases the implementation by localizing the content to align with current staffing, organizational structure, and social and cultural aspects of the organization. However, this process must identify and preserve the essential features and attributes of the evidence-based solution to maintain the fidelity of the solution and ensure that the key drivers can still be applied to the opportunity. This process will likely be iterative, and the minimally viable prototype established in this step is likely to be refined in subsequent steps.

Step 5: Perform Implementation Sprints. At this point the implementation truly begins, as the localized minimally viable prototype (MVP) is incorporated into the healthcare delivery organization. This is also when the evaluation of the MVP's performance begins and individual aspects of the MVP that need adjustment or alteration can be identified. The scientist and other key members facilitate "sprint" cycles, which are short, intense experimentation periods where the MVP is tested and feedback is gathered from staff regarding potential improvements or modifications. These alterations may be to improve the efficacy of the MVP, to more completely localize the MVP to the setting and situation, or both. These sprints continue iteratively until all involved agree that no further improvements can be made to the MVP. The success of these sprints relies on the full participation of staff, who must feel comfortable sharing their experiences and offering constructive (but potentially critical) feedback regarding the process. Here is where the scientists' mindsets are often called upon to promote the necessary openness and dialogue, but ensuring that activities remain in line with the parameters of budget and timeline that have been previously established.

Step 6: Monitor Sprints. In this step, the scientist and the implementation team develop feedback loops to monitor the fidelity and performance of the localized evidence-based solution. These results are communicated to the entire team and lessons learned can be discussed and applied to improve the implementation process. Often, these lessons have less to do with the solution itself

and more to do with the dynamics and social structure of the healthcare delivery organization. This step is critical for defusing any tension and maintaining communication and teamwork throughout the remainder of the Agile Implementation process.

Step 7: Monitor the Impact on the Entire Organization. Also necessary is feedback regarding the impact of the implemented solution on the overall quality and financial performance of the entire organization. As described by agile science, all areas of the healthcare delivery network are interconnected, so that any change in one area will affect the entire network. This process not only detects unintended or adverse consequences of the implementation, but also identifies emergent opportunities or additional benefit not previously recognized.

Step 8: Develop a Minimally Standardized Operating Procedure. If the implementation successfully met internal demands, solved the targeted problem, and proved to be financially viable, then it is necessary to document the details of the finalized solution in a minimally standardized operating procedure manual. This manual contains the key aspects of the solution and provides guidance for how to scale the solution or apply it to other settings. During subsequent application, this manual will likely be updated as additional learnings are gained from experiences across other areas of the organization or in other organizations.[20,21]

Shifting Academic Incentives

AHRQ's research grants are often awarded to principal investigators in academic institutions. Thus, one set of opportunities that Roundtable members discussed was leveraging changes in the incentives academic investigators face. This includes addressing barriers to community collaboration and academic constraints.

Community Collaboration

Throughout the day, participants discussed the importance of involving communities in research that affects their members, which in this case would involve ensuring active engagement with communities of older adults. At the same time, participants noted significant barriers to such engagement:

> Being in academia and doing community-engaged work, the academic setting and the bureaucracy that exists there makes it nearly impossible to really engage with the community and to reflect the priorities and the values of the communities.

The conversation also included an emphasis on the importance of having older adults from the community, and patients more generally, involved from the beginning of the grant process:

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[20] Mehta J, Aalsma MC, O'Brien A, et al. Becoming an Agile Change Conductor. Front Public Health. 2022 Dec 14;10:1044702. doi: 10.3389/fpubh.2022.1044702;

[21] Lindroth H, Schumaker C, Taylor B, Boustani Z, Boustani M. Agile Mentorship: A Longitudinal Exploratory Analysis. ATS Scholar. https://doi.org/10.34197/ats-scholar.2022-0035PS

We need to assume older patients and their caregivers are involved in every stage of the work we do, the clinical research, from developing the hypotheses all the way through writing the papers and getting appropriate recognition for that. They need to be on our guideline panels, they need to be on measure development panels, and they need to really be part of any demonstration project that we move forward.

Opportunities are available to structure funding announcements that require and provide resources for community-engaged research. This includes providing funding to pay community members for their time, sharing tools that help researchers better engage community members, and instituting funding announcement requirements that involve community members in designing and implementing interventions to improve the health and well-being of older adults.

Academic Constraints
Currently, academic incentives are aligned to encourage principal investigators to obtain large grants to fund their research and to ensure that their research results appear in numerous peer-reviewed journal articles. These incentives, combined with the financial incentives that academic centers face, pose significant barriers to conducting innovative research that helps scale and spread proven solutions.

As one participant noted:

I'm struck by … the innovator phenomenon that I've been seeing. [A] group of people… identify a problem that exists and then a solution for that problem. And they can go to a funder, NIH [National Institutes of Health] or AHRQ and get it funded and do a clinical trial of it. And it gets published in a good journal because it's got good results and we're good investigators.

And it sits there because there isn't an incentive model to scale and spread this. … I have some really great colleagues who are doing things around homelessness intervention and food insecurity and care transitions. People come up with creative models but [there is] no incentive structure, so they sit there.

So, we take this to our commercialization office in our academic centers and they look at it and there's no IP [intellectual property], there's nothing to patent, there's nothing that they can commercialize. And so, we go back to our drawing board.

How do we move beyond that and … incentivize … the … demand that's needed to scale and spread [proven interventions]? And perhaps that's the way we should be thinking about even funding these ideas [and] concepts: …what is your model for scale and spread? To what extent do you actually have buyers of this program if it actually is successful? And make that part of the packaging or the development of the program.

When referring to researchers engaging in the real-world changes that their healthcare systems are attempting, one Roundtable member emphasized the following:

> The time that I spend is just voluntary because I want to help the hospital system. But in terms of what I'm being rated on, I need to do papers, I need to do grants and so all of the time that I spend helping them is subtracting from my own time. But then that's where the actual implementation is happening. So that's why I want to help out with that.

A participant highlighted the incentives in grant writing to develop innovative ideas rather than to respond to existing demand. This participant suggested requiring the "Significance" section of grant applications to include a demonstration of current demand and a description of how the investigator proposes to monitor demand for the proposed intervention.

There is a need to fund projects that specifically target the adaptation, scale, and spread of programs that have been shown to improve the health of older Americans. Drawing from implementation research, the field of localization (the adaptation of products and services to meet the needs of a particular population), and other relevant areas of study, such funding opportunities could also include strong incentives to collaborate with communities.

Clinician Training
Several Roundtable members raised the issue of physician training and its impact on care for older adults, with two areas of focus. The first included the perception among medical students that primary care is a difficult and poorly reimbursed area in which to work and the challenges this perception poses to medical students considering whether to enter primary care and provide care to older adults.

The second area of focus involved highlighting the opportunity to conduct research that would evaluate and demonstrate the benefit of community-based primary care residency training for physicians. One participant commented that 80 percent of residency training is conducted in hospitals and is supported by Medicare's Graduate Medical Education funding. On the rare occasions when other funding is available to support community-based residency, those programs have drawn significant interest from medical students.

The opportunity exists to develop an evidence base regarding the impact of community-based residency training on care for older adults. This evidence base would include outcomes such as the proportion of residency graduates who later work in community-based primary care, the impact of such programs on the quality of care, and the different approaches to care coordination and coordination with CBOs that such program graduates may take.

Broadening Impact

Barriers to Scale and Spread of Successful Programs

Participants discussed barriers to scale and spread, including funding and payment mechanisms; metrics; necessity for culture change in health systems and practices; the complexity of patient care; and other problems inherent to the scale and spread of interventions. Participants also discussed the challenges to getting aging as a priority on policy and healthy system agendas, and lack of awareness of the many opportunities to improve care.

Funding and payment mechanisms. Roundtable participants noted the lack of funding for many innovative programs that support healthy aging in both health systems and communities. Sustainability of innovative programs after initial funding ends is challenging if the services provided are not covered by health insurance or dedicated funding streams, including those delivered by interdisciplinary teams, social workers, and others:

> Theoretically in the healthcare system you bill for it, [and] you can keep it sustainable once it's billed, but on the community side it's much harder to keep it sustainable because there needs to be somebody who's paying for that intervention.

Metrics. The lack of alignment among the metrics used to measure quality and/or judge success and the desired results of interventions is one barrier to scale and spread. Most metrics in healthcare assess adherence to clinical processes and drive reimbursement and thus the care that patients receive. Prevalent metrics rarely capture patients' goals and priorities, including the need for services outside the healthcare system that support their health and well-being. As a result, community-based services—often key to effective models of support for older adults—generally are not included in these metrics.

Complexity of patient care. The complexity of patient care and the paucity of evidence on management of people living with multiple chronic conditions poses a barrier to the effective scale and spread of models for older adult care:

> … how do I take care of the person in front of me? I need to use evidence and guidelines, that's my basis. That's how I know I'm doing the right thing … And … it works elegantly when you're 50 and you have one condition, especially if it's an acute condition, but when you're 75 and you have six conditions and some functional impairment, it doesn't work so well. So, it creates a mess, and it doesn't get you where you want to go. But on the clinician side, it produces the system that we have and that's where the reimbursement is.

Problems inherent to the scale and spread of interventions. Participants discussed several problems that are inherent to the scale and spread of successful models, including the following:

- The need to understand the context of the original intervention and address contextual differences that may affect scale and spread in other organizations and communities
- Not knowing what models are truly ready to scale and spread
- Losing inherent features of the initial program process during scale and spread, particularly losing patient and community involvement in the design
- Understanding the core elements required for each program, where fidelity to those elements is essential, and what can be adapted to local cultures, resources, and contexts

Solutions to Address Barriers

Roundtable participants emphasized the need for dissemination, implementation science, and a focus on the scale and spread of successful programs to support the health and well-being of older adults. They also discussed the importance of turning existing evidence into actionable knowledge. Members suggested opportunities to support research focused on why proven programs fail to be disseminated or implemented beyond their original settings, to identify how and why specific planned changes work well in particular contexts, and to understand the resources needed and the constraints that affect scale and spread. Opportunities are also available to help grantees engage in implementation science, disseminate the best practices identified in their research, and understand the science behind the successful scale and spread of evidence-based practices and programs.

Panelists also discussed the importance of creating "virtuous learning cycles" to enhance real-world, healthy aging. By learning from and building on the existing evidence base of programs and practices, it is possible to develop research capabilities that foster and speed such learning cycles and create more efficient dissemination, scale, and spread. Several panelists noted the existence of good maturity models for learning communities, health systems, and organizations. They articulated the potential to identify these model characteristics and develop measures to assess an organization's ability to become a learning system.

Beyond this, Roundtable members suggested the possibility of creating interventions that are more amenable to scale and spread by considering the need for widespread adoption in the design of programs from their inception. This would involve designing innovations based on limited resources to create different developmental pathways that are easier to disseminate successfully. One panel member also suggested designing agile interventions so that they can be changed and adapted as needed. They added that healthcare systems' investments in time commitments and innovation capital in planning efforts are limited. Therefore, it is important to get health systems leadership support for approaches to improve the care of older adults among multiple competing priorities and to ensure that programs and practices can be readily adapted as learning occurs to increase their chances of success.

Accountability and Aligning Incentives

Aligning incentives to provide high-quality, coordinated care to older adults in order to encourage their scale and spread was a recurring theme throughout the Roundtable. Participants identified opportunities to encourage hard thinking about what healthcare outcomes and quality measures matter most—with a focus on moving beyond disease-oriented measures—and how incentives can be aligned throughout the healthcare and social services sectors to set priorities and produce those outcomes.

Roundtable members emphasized that incentive structures currently favor existing models of fragmented, fee-for-service care. They also highlighted the ways in which supply-side incentives drive healthcare because large healthcare systems need to pay for the equipment, space, and personnel they have built into their systems. As a result, hospitals and healthcare systems are incentivized to focus on high-paying procedures and to de-emphasize primary care. As one Roundtable member described:

> Three weeks ago, I had a hip replacement, and it was the most amazing health experience I've had in my entire life. It was team-based, it was efficient, it was streamlined. I'm a 66-year-old man, degenerative joint disease, dropped off at 7:00 AM and picked up at 1:00 PM. Went through everything from getting evaluated by the PT, very team-based care, very focused, and very, very lucrative for my healthcare system.

> And I contrast that with my work as a primary care physician, which is chaotic, extremely messy. I'm saying, why can't what I just went through, why can't that be like when I'm taking care of my older adult patients who have multiple chronic conditions? … I realized in trying to do this [improve primary care] in my own healthcare system, the biggest issue is convincing the CEO. If I can't do that, I'm a goner. It's not going to happen. And I realize the things that are most attractive to the CEO [are procedures like] that lucrative joint replacement, six-hour experience, and … the work I'm really trying to do for my [primary care] patients is much less attractive.

Roundtable members discussed ways to align incentives through value-based payment and value-based care arrangements. They noted that such arrangements would only serve to improve the health and well-being of older adults if effective measures are used that truly matter to older adults and if healthcare systems, insurers, and clinicians are held accountable for such outcomes.

As one example of aligning incentives, a Roundtable participant encouraged AHRQ to consider approaches to establishing shared accountability between providers where, for example, a psychiatrist and an internist respectively treating an individual patient's depression and diabetes would each be held accountable for the patient's outcomes for both conditions.

Speakers also noted that value-based healthcare organizations are now working directly with CBOs and funding them to address the SDoH needs of older adults as a way to improve health and lower healthcare costs. AHRQ could consider working to identify and evaluate the impact of such value-based models based on the alignment of incentives to produce desired outcomes, and has opportunities to encourage the dissemination of such models if proven successful.

Promising Approaches for Health System Transformation

Roundtable members discussed several approaches that could help support the health system transformation needed to provide age-friendly care and optimize older adults' health and well-being. These approaches included the following:

- Identifying programs that are ready to spread and aligning financial and other incentives to support their implementation
- Finding windows of opportunity that may uniquely create readiness for change
- Supporting program champions who are willing to carry the message and be program standard bearers
- Defining structures and processes that are essential for success
- Identifying disruptors that can challenge the status quo

Summary

The AHRQ Optimizing Health and Functional Status as We Age Roundtable identified many opportunities to improve the health and well-being of older adults in the United States.

In developing a truly equitable, person-centered healthcare system, opportunities are available to focus on individuals' health goals and priorities, address health-related social needs, as well as SDoH more broadly, and to ensure that patient and caregiver voices are included in program design and oversight. Throughout the day, participants highlighted the need for partnerships with community and social services organizations to address social needs and articulated a set of principles to support the design and implementation of effective care models. Partnerships and alignment between clinical care and public health will also be needed to improve the health and well-being and reduce health inequities among older adults.

A second area of emphasis involved generating evidence on what works to transform care. This included improving data and metrics, moving beyond a focus on RCTs, and aligning research approaches with health system leaders' interests. The conversation also focused on shifting academic incentives and included community collaboration, addressing academic constraints, and changing clinician training.

The final area of opportunity focused on broadening impact, including the dissemination, scale, and spread of successful programs; barriers to doing so; and potential solutions to address those barriers. The conversation also emphasized aligning incentives and focusing on accountability and promising approaches for health system transformation.

It was apparent that much innovative work is going on across multiple sectors, including healthcare, public health, social and community health and the age friendly health systems and age friendly public health initiatives. There is great potential to accelerate progress by aligning, creating synergies, and collaborative learning across these efforts. The Roundtable provided important insights on how AHRQ-sponsored research can catalyze innovation and generate the critical evidence to support the transformation of health systems so that they improve access, quality, outcomes, and equity of care as the U.S. population ages.

Appendix 1: Models for Maximizing Older Adult Health and Well-Being

Roundtable participants mentioned several models and programs designed to address the full range of health and well-being needs of older adults. These descriptions are provided from the listed citations either verbatim or lightly edited.

Age-Friendly Cities and Communities
https://extranet.who.int/agefriendlyworld/age-friendly-cities-framework/

> The WHO Age-friendly Cities framework proposes eight interconnected domains that can help to identify and address barriers to the well-being and participation of older people. These domains are community and healthcare, transportation, housing, social participation, outdoor spaces and buildings, respect and inclusion, civic participation and employment, and communication and information.

https://www.aarp.org/livable-communities/network-age-friendly-communities/

> The AARP Network of Age-Friendly States and Communities serves as a catalyst to educate local leaders (both elected officials and engaged residents) and encourage them to implement the types of changes that make communities more livable for people of all ages and especially for older adults. The network provides cities, towns, counties, and states with the resources to become more age-friendly by tapping into national and global research, planning models, and best practices.

Age-Friendly Health Systems
https://www.johnahartford.org/grants-strategy/current-strategies/age-friendly/age-friendly-health-systems-initiative;
https://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx.

> Health systems are frequently unprepared to care for older adults, leading older adults to suffer disproportionate harms. To address this challenge, in 2017, The John A. Hartford Foundation (JAHF) and the Institute for Healthcare Improvement (IHI), in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA), set a bold vision to build a social movement so that all care with older adults is age-friendly care. Age-friendly care follows an essential set of evidence-based practices, causes no harm, and aligns with What Matters to older adults and their care partners.

> Becoming an Age-Friendly Health System (AFHS) entails reliably providing a set of four evidence-based elements of high-quality care, known collectively as the 4Ms (what matters, medication, mentation, and mobility), to all older adults in a healthcare setting or system. When implemented as a set, the 4Ms represent a broad shift by health systems to focus on the needs and evidence-based care of older adults.

Age-Friendly Public Health Systems

https://afphs.org/

> Every day, 10,000 Americans turn 65. The public health sector's focus on prevention has had a profound impact on longevity in the United States, and yet, historically and pre-pandemic, public health has not embraced efforts to improve the health and well-being of older adults. As the demographics of our population continue to shift, public health should elevate healthy aging as a core public health function, with a foundational focus on equity. To facilitate this transformation, Trust for America's Health, in partnership with The John A. Hartford Foundation, developed the Framework for Creating Age-Friendly Public Health Systems. This Framework is based on 6Cs that outline six areas of age-friendly public health activities:
>
> - Creating and leading policy, systems, and environmental changes to improve older adult health and well-being
> - Connecting and convening multi-sector stakeholders to address the health and social needs of older adults through collective impact approaches focused on the SDoH
> - Coordinating existing supports and services to help older adults, families, and caregivers navigate and access services and supports, avoid duplication, and promote an integrated system of care
> - Collecting, analyzing, and translating relevant and robust data on older adults to identify the needs and assets of a community and inform the development of interventions through community-wide assessment
> - Communicating important public health information to promote and support older adult health and well-being, including conducting and disseminating research findings, and emerging and best practices to support healthy aging.
> - Complementing existing health promoting programs to ensure they are adequately meeting the needs of older adults.

CAPABLE

https://nursing.jhu.edu/faculty_research/research/projects/capable/

> Community Aging in Place—Advancing Better Living for Elders (CAPABLE) is a person-directed, home-based program that addresses both function and healthcare expenses. The four to five-month program integrates services from an occupational therapist, a registered nurse, and a handy worker who work together with the older adult to set goals and direct-action plans that change behaviors to improve health, independence, and safety.

GRACE Team Care

https://archive.ahrq.gov/workingforquality/priorities-in-action/index.html#grace

> Geriatric Resources for Assessment and Care of Elders (GRACE) Team Care was initially developed and implemented more than a decade ago by the Indiana University School of Medicine's Center for Aging Research to assist primary care clinicians working with low-income older adults to optimize their health and well-being and prevent unnecessary nursing home placement.

NCCARE360

NCCARE360 is the first statewide coordinated care network that better connects individuals to local services and resources. NCCARE360 provides a solution to a fragmented health and human services system by connecting providers and organizations across sectors in a shared technology network. In the NCCARE360 network, providers can electronically connect individuals and families who have unmet social needs to community resources. NCCARE360 also allows for easy feedback and follow-up to help close the care loop for individuals and families seeking help by:

- Communicating important public health information to promote and support older adult health and well-being, including conducting and disseminating research findings and emerging and best practices to support healthy aging
- Complementing existing health-promoting programs to ensure they are adequately meeting the needs of older adults

UK National Health Service Social Prescribing

- Social prescribing is … an approach that connects people to activities, groups, and services in their community to meet the practical, social, and emotional needs that affect their health and well-being. In social prescribing, local agencies such as local charities, social care, and health services refer people to a social prescribing link worker. Social prescribing link workers give people time—focusing on "what matters to me?"—to coproduce a simple personalized care and support plan, and they support people in taking control of their health and well-being.

Appendix 2: Meeting Agenda

AHRQ Roundtable: Optimizing Health and Function as We Age
April 14, 2023, 8:30 a.m. – 4:00 p.m. Eastern

Meeting Agenda

8:00 – 8:30 a.m.	**Registration**
8:30 – 9:15 a.m.	**Welcome Remarks and Overview** ▪ Robert Otto Valdez, PhD, MHSA, Director, Agency for Healthcare Research and Quality ▪ Arlene Bierman, MD, MS, Chief Strategy Officer, Agency for Healthcare Research and Quality
9:15 - 10:30 a.m.	**Blue-Sky Discussion with Attendees** ▪ Jerry Gurwitz, MD, Chief, Division of Geriatric Medicine, UMass Chan Medical School ▪ Jane Carmody, DNP, MBA, RN, FAAN, Senior Program Officer, The John A. Hartford Foundation ▪ Aanand Naik, MD, Professor and Executive Director, UT Health Houston
10:30 - 11:00 a.m.	**Person and Community Voices** ▪ Caroline Hartfield, Healthy Lifestyle Coach, Lifestyle Management LLC ▪ Adriana Perez, PhD, Anthony Buividas Term Chair in Gerontology, Associate Professor of Nursing, and Senior Fellow, Leonard Davis Institute for Health Economics, University of Pennsylvania School of Nursing ▪ Richard Knight, MBA, Past President, American Association of Kidney Patients
11:00 - 11:10 a.m.	**Break**
11:10 - 11:50 a.m.	**Clinician, Practice, and Health System Voices** ▪ Helen Burstin, MD, MPH, CEO, Council of Medical Specialty Societies ▪ Adrienne Mims, MD, MPH, CMO, Rainmakers Strategic Solutions ▪ Tara Pearse, MS, LCSW, Assistant Vice President, Social Work Services, Northwell Health

11:50 a.m. - 1:05 p.m.	**Lunch and Breakout Groups**
	  Breakout #1: Developing and Implementing Models of Care to Foster Aging Well
	
	  Breakout #2: Developing Partnerships with Communities, Public Health, and Social Care
	
	  Breakout #3: Generating Evidence on What Works to Transform Care (Evaluation, Research Methods, Implementation)
	
	  Breakout #4: Scaling and Spreading Effective Models and Approaches

1:05 - 1:20 p.m.	**Break**
1:20 - 1:50 p.m.	**Breakout Session Report Outs**
1:50 - 2:30 p.m.	**Beyond Healthcare: Integration with Public Health and Social Care; Engagement of Other Sectors (e.g., Transportation, Housing, Food Security, Parks and Recreation); and Addressing Social Determinants of Health** ■ John Auerbach, MBA, Senior Vice President, Federal Health, ICF ■ Patricia D'Antonio, BSPharm, MS, VP, Policy and Professional Affairs, The Gerontological Society of America ■ Kathleen Cameron, BSPharm, MPH, Senior Director, National Council on Aging
2:30 - 3:15 p.m.	**Innovation and Evidence Generation** ■ Malaz Boustani, MD, MPH, Professor of Aging Research, Indiana University ■ Harold Pincus, MD, Professor and Vice Chair of Psychiatry, Co-Director CTSA at Columbia University ■ Judy Zerzan-Thul, MD, CMO, Washington State Health Care Authority
3:15 - 4:00 p.m.	**Putting It All Together and Taking Action: Opportunities for Discovery and Innovation**
4:00 p.m.	**Adjourn**

Appendix 3: Roundtable Participants

John Auerbach, MBA, ICF

Arlene Bierman, MD, MS, Agency for Healthcare Research and Quality

Rachael M. Boicourt, MHS, Agency for Healthcare Research and Quality

Alice Bonner, PhD, RN, FAAN, FAANP, Institute for Healthcare Improvement

Malaz Boustani, MD, MPH, Indiana University

Nicole J. Brandt, PharmD, MBA, Lamy Center, University of Maryland School of Pharmacy

Melinda B. Buntin, PhD, Vanderbilt University School of Medicine

Helen Burstin, MD, MPH, Council of Medical Specialty Societies

Kathleen A. Cameron, BSPharm, MPH, National Council on Aging

Jane Carmody, DNP, MBA, RN, FAAN, The John A. Hartford Foundation

Maria Torroella Carney, MD, FACP, Northwell

Keith T. Chan, PhD, Hunter College/Ways and Means

Jonathan E. Cohen, JD, MPhil, University of Southern California

Thomas Cornwell, MD, VillageMD

Kelly Cronin, MPH, MS, Administration for Community Living

Patricia M. D'Antonio, BSPharm, MS, The Gerontological Society of America

David A. Dorr, MD, MS, Oregon Health & Science University

Maya Gerstein, MPH, Agency for Healthcare Research and Quality

Jerry H. Gurwitz, MD, UMass Chan Medical School

Carolyn L. Hartfield, Lifestyle Management, LLC

Peter Hollmann, MD, Brown Medicine

Gretchen Jacobson, PhD, The Commonwealth Fund

Melinda Kelley, PhD, National Institute on Aging, National Institutes of Health

Richard Knight, MBA, Past President, American Association of Kidney Patients

Alex H. Krist, MD, Virginia Commonwealth University

Adam S. Levine, PhD, Johns Hopkins University

Shari M. Ling, MD, Centers for Medicare and Medicaid Services

Tabassum Majid, PhD, MA, PCORI

Trisha Milnes, AuD, MHA, Charlie Norwood VA Medical Center

Adrienne Mims, MD, MPH, Rainmakers Strategic Solutions

Aanand D. Naik, MD, UTHealth Houston

Tara Pearse, MS, LCSW, Northwell Health

Adriana Perez, PhD, University of Pennsylvania School of Nursing

Harold A. Pincus, MD, Columbia University

Mark H. Pitcher, PhD, National Center for Complementary and Integrative Health, National Institutes of Health

Marisa Scala-Foley, USAging

Marianne Shaughnessy, PhD, CRNP, Veterans Health Administration

Robert Otto Valdez, PhD, MHSA, Agency for Healthcare Research and Quality

Melissa Wei, MD, MPH, MS, University of California, Los Angeles

Joan C. Weiss, PhD, Health Resources and Services Administration

Megan Wolfe, JD, Trust for America's Health

Judy Zerzan-Thul, MD, Washington State Health Care Authority