SOCIAL INNOVATIONS Journal
Vol. 24 (2024): Innovations in Cross-Sector Collaborations: An Approach to Increase Ecosystem and Place-Based Impact

Engaging Key Stakeholders in the Development of a Framework & Toolkit for Age-Friendly Cross-Sector Care Coordination: *Three Keys* for Aligning the Health Care & Public Health Sectors

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Keywords: older adults, age-friendly care, care continuum, health equity, implementation

Abstract

The Institute for Healthcare Improvement (IHI), the Michigan Health & Hospital Association (MHA), and Trust for America's Health (TFAH) are working to improve how public health and healthcare organizations work collaboratively across the cross-sector care continuum to deliver better outcomes for older adults. They have developed evidence-based guidance on the co-creation of interventions that bridge gaps in resources, care, and systems across the healthcare and public health sectors, which are derived from the qualitative results of semi-structured focus groups. The result is an evidence-based framework and accompanying implementation toolkit developed for use by public health leaders, health systems leaders, and community-based organizations in the development of shared strategies and programs to support the coordination of care for older adults in the places they call home. *Improving Public Health and Health Care for Older Adults: The Three Keys to Cross-Sector Age Friendly Care Implementation Guide and Workbook* is a toolkit that builds on prior work in Age-Friendly Health Systems, Age-Friendly Public Health Systems, and Age-Friendly Ecosystems.

Developed to support the reduction of gaps in services at points of transition or referral in the care continuum, the resulting framework and accompanying toolkit contains specific recommendations and guidance for practitioners working in the public health and healthcare sectors that pairs the literature from the field with results from semi-structured interviews and other methods. This paper describes how to engage key stakeholders in the development process and how the information gathered informed the development of our framework. Together, these resources support the co-creation of programs and strategies that center older adults and health equity at all stages. The toolkit includes visual narratives depicting the multidimensional relationship between an individual and services and emphasizes the importance of assessing and acting on what matters most to older adults and their caregivers.

Introduction

As older people age, care tends to become more complex, a challenge compounded by gaps in services at points of transition and limitations on care coordination across care settings. These settings include healthcare, public health, and the community (including aging services), which have historically been siloed. Embodying age-friendly cross-sector care coordination is vital, not

only to improve outcomes for current older adults but also for future generations of people as they age.

The Institute for Healthcare Improvement (IHI), the Michigan Health & Hospital Association (MHA), and Trust for America's Health (TFAH) are working to improve how public health and healthcare organizations work collaboratively across the care continuum. They have developed evidence-based guidance for the co-creation of interventions that bridge gaps in resources, care, and systems across the healthcare and public health sectors.

Health systems and supportive organizations participating in the Age-Friendly Health Systems (AFHS) movement reliably provide a set of evidence-based elements of high-quality care, known as the 4Ms, presented in Table 1, to older adults. As a set, these interventions have been shown to reduce harm and improve health outcomes while avoiding unwanted or duplicative care[i].

TABLE 1. *The Framework for an Age-Friendly Health Systems outlines four elements of high-quality care for older adults*[ii]

Framework Elements: 4Ms	*Description*
What matters	Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care and across settings of care.
Medication	If medication is necessary, use age-friendly medication that doesn't interfere with What Matters to the older adult.
Mentation	Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.
Mobility	Ensure that older adults move safely every day in order to maintain function and do What Matters.

As of February 2024, 3,821 health systems have been recognized as AFHS participants, with more than 2,000 of these reaching older adults with 4Ms care.

Currently, five states, including Florida, Michigan, and Mississippi, and ten state public health institutes are implementing the AFPHS framework.[iii] Florida developed an innovative, state-specific prototype that has been adopted in 50 of 67 county health departments, defining public health's role in ensuring older adults achieve and maintain their optimal health and well-being. In Washington, an AFPHS Learning and Action Network comprises teams of local health jurisdictions and area agencies on aging, including the Northwest Washington Indian Health Board. Age-Friendly Public Health Systems (AFPHS) include six core functions (6Cs) that describe this kind of collaboration presented in Table 2.[iv]

TABLE 2. *The Framework for Creating Age-Friendly Public Health Systems incorporates six core public health activities that support healthy aging*[v]

Framework Elements: 6Cs	*Description:*
Creating	Creating and leading policy, systems, and environmental changes to improve older adult health and well-being.
Connecting	Connecting and convening multi-sector stakeholders to address the health and social needs of older adults through collective impact approaches focused on the social determinants of health.
Coordinating	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	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	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	Complementing existing health promoting programs to ensure they are adequately meeting the needs of older adults.

As the AFHS movement grows, health systems are increasingly looking outside the walls of their institutions to support older adults in community settings. In collaboration with public health, community, and aging services, health systems, which have been historically siloed, can better support healthy aging and address the challenges and opportunities to improve cross-sector care coordination.

According to the WHO, by 2030, people ages 60 and older will constitute over 16% of the global population, and by 2040, older adults are expected to account for more than 21% of the United States population.[vi] With this growth comes increased demand for healthcare services. Current healthcare delivery systems and community supports are not adequately aligned with the complex needs of older adults and often fall short when these systems are unprepared, unable to communicate across sectors and systems, and have unreliable access to services.[vii]

Care coordination is meant to promote communication and continuity of care across providers, specialties, and systems, with the ultimate goal of reducing healthcare costs and improving clinical outcomes for older adults.[viii] Such care is important not only in the management of complex acute care needs and post-hospital transitions but also in the day-to-day management of chronic illnesses in acute and community settings.[ix]

Despite the success of the Affordable Care Act at increasing access to care, substantial gaps in care coordination remain across care settings, healthcare systems, and in the community.[x] Analyses of data from the 2021 Health and Retirement Study found that about 40% of older adults perceived poor care coordination.[xi] To address challenges to care transitions for older adults, several states are implementing age-friendly cross-sector care coordination. One of these states, Michigan, was selected to serve as the pilot for the developed framework that bridges public health and healthcare systems, along with other community-based partners.

It's well known across disciplines, files of study, and across sectors that it is critical to involve those with lived experience of inequity in the development, design, and delivery of programs and initiatives.[xii] To ensure that the framework was responsive to the needs of older adults, their caregivers, and the organizations that serve them, the project team engaged those with lived experience in developing the care coordination framework. Specifically, a series of semi-structured interviews and feedback sessions (on framework elements) were conducted with two stakeholder groups - older adults and/or their caregivers and organizational leaders. This paper describes how to engage key stakeholders in the development process and how the information gathered helped inform our framework.

Methods

To inform development of the framework, the IHI led a series of stakeholder interviews with two groups: older adults and/or their informal caregivers (n = 13), and organizational leaders (n = 12). Participants in both groups provided informed consent and were instructed by the project team that the information they provided would be reported in aggregate.

Organizational and service sector leaders were recruited by the project team through their networks and existing relationships in the older adult and aging services sector. The project team worked to ensure that all sectors were represented with at least two interview participants from each of the following sectors: academia, advocacy, public health, community health, hospital leadership, and government. These participants were interviewed to identify and understand gaps in resources, care, and systems serving the health of older adults in Michigan.

Then, semi-structured qualitative interviews were conducted with adults over the age of 60 and/or caregivers to identify and understand care gaps and challenges for older adults. Thirteen older adults were recruited from 5 Michigan cities. The MHA used patient and family advisory boards in health systems they support as a vehicle for recruiting the participation of older adults and caregivers. Additional recruitment was led by the IHI through their networks and staff.

Interviews with those older adults and/or caregivers were facilitated telephonically or virtually,

except for two, which were conducted in person. Virtual, semi-structured interviews were conducted via the Zoom platform, with audio and video recordings captured and confirmation that information would be anonymized. All interview transcripts were reviewed for accuracy and de-identified. Interviews were open-ended and approximately 1 hour in duration. Demographics such as age, race/ethnicity, health status, location, and socioeconomic status were self-described by participants prior to the interview start. Questions were developed to assess older adults' and caregivers' views of age-friendly cross-sector care coordination as well as current challenges that prevent access to the resources they need to live a healthy life. Participants were asked to describe an acute healthcare event, challenges experienced in acquiring needed care and services post-discharge, and what could be done to improve their care transition in the future. Similar questions were asked of organizational leaders with an additional focus on recommendations for a better, cross-sector care continuum. To center equity and close equity gaps, the following demographic characteristics narrowed the scope and analyzed the data from the interview process: 1) race and ethnicity, 2) geography type, 3) health conditions and status, and 4) insurance status. These demographics were selected to center equity in the process.

Analysis followed Braun and Clarke's thematic method.[xiii] The project team had two members review the transcripts for every interview and code for as many topics (themes) as possible and applied codes to contextual segments, then sorted codes into higher-level topics using tables. Higher-level topics were refined and renamed depending on the extent to which the sorted data were supportive of said theme. No software was used to analyze this data.

Results

Seven of 13 older adults and/or caregivers identified as people of color, with all participants having diverse ages and socioeconomic statuses, with 38% identifying as low-income. Interviews included participants from rural (53%), urban (38%), and suburban (9%) communities. The number of interviews with older adults was selected based on the ratio of interested older adults that mirrored the racial and geographic spread of older adults in Michigan.

Current challenges in and future directions for transitional care for older adults were drawn from analysis of the stakeholder interviews with organizational leaders, older adults, and caregivers along nine major themes: accessibility of care (noted by both groups of stakeholders), affordability of care (older adults/caregivers only), care coordination and navigation (older adults/caregivers only), caregiver support (older adults/caregivers only), collaboration and communication (organizational leaders only), culturally-centered and equitable care (older adults/caregivers only), older-adult-centered care (both stakeholder groups), program funding (organizational leaders only), and workforce development (both stakeholder groups). Table 3 presents key findings by each of the nine themes according to current challenges and future directions or suggested improvements for coordinated care delivery for older adults transitioning from one care setting to another.

TABLE 3. Major Themes: Challenges and Opportunities

Current Challenges	Future Directions
1. Accessibility of Care *The ability to navigate and access (either physically or through technology) the available services and supports.*	
• Need for increased awareness of appropriate programs and services with misalignment between services needed and services available. • Discomfort with digital health interventions, including telehealth. • Need for improved transportation options to reach services in rural communities.	• Developing informed tools that allow for the identification of appropriate services within a given geography. • Organizing services according to what matters to older adults to ensure services are available to older adults at times that they are most needed. • Locating services where people are instead of people traveling to services.
2. Affordability of Care *A complex system and policy environment that should support older adults and their caregivers in understanding the types of coverage, benefits, and resources that are available at any given time and the ability to pay for the services, (such as dental coverage) and other resources (such as medication) needed to live a healthy life.*	
• Need for financial support for nursing or home care services. • Expensive or costly co-payments and transportation costs. • Need for increased health insurance literacy for older adults and caregivers.	• Providing financial assistance for nursing and home care services. • Reducing co-payments and financial support. • Health insurance literacy education.
3. Care Coordination and Navigation *An intentional approach to aligning, sharing information, and communicating across sectors. It's important to understand "What Matters" to the older adult and their caregivers as part of the care coordination process so that the information can be used to achieve better, safer, and more effective care and outcomes across the continuum.*	
• Need for increased community resources available in rural areas. • Shortage of community health workers and case managers. • Need for improved of communication about programs offered by different organizations, with limited referral tracking and follow-up.	• Recruiting and training community health workers and case managers. • Improving connections and communication between health systems and community services. • Adopting a bi-directional platform that allows for sharing of medical records across different organizations.

• Poor discharge planning and transitions of care resulting in medication error • Need for increased information sharing among providers (multiple EHR platforms in place).	• Engaging and supporting caregivers at all points of care, especially in the discharge process.
3. Caregiver Supports *The individual- and system-level supports to support the health and care of older adult.*	
• Need for increased education and training on caring for older adults. • Need for support and guidance from healthcare professionals. • Recognition of the financial challenges and burden that caregivers experience.	• Caregiver training on resource navigation and health insurance literacy. • Caregiver resource map to help caregivers navigate healthcare and community services. • Financial assistance for caregivers.
4. Collaboration and Communication *How healthcare and public health organizations and entities communicate, collaborate across sectors, share information, transition older adults seamlessly across the care continuum, and provide the right resources for older adults and their caregivers, at the right time.*	
• Need for improved communication about programs across health system and community sectors. • Need for alignment and common vision around goals, priorities, and measures for collaborating organizations. • Need to move beyond relationship-based partnerships.	• Leveraging Medical Assistants, community health workers, and social workers to support collaboration and communication across sectors. • Developing and using a common language and measures across programs and services provided in the Age-Friendly Ecosystem. • Broadening and deepening partnerships across sectors with guidance on communication, coordination, and collaboration.
5. Culturally Centered and Equitable Care *Integrates the culture, language, and other important racial, ethnic, tribal, or other demographic factors that matter to the older adult and their caregivers in the delivery of the care, as well as resources needed to maintain or improve their health and well-being.*	

• Need for increased staff diversity in nursing home and long-term care facilities. • Need for on-site translators, in addition to multilingual providers and clinical staff. • Demand for preventative health services in BIPOC communities.	• Recruiting and retaining a diverse workforce that reflects communities in which older adults live. • Providing translation of services and materials in advance and on demand. • Training healthcare providers in cultural competence.
6. Older-Adult-Centered Care *Reinforces what matters to older adults and their caregivers (including family or chosen family) in the experience of their care across public health and healthcare.*	
• Need for social connection outside home. • Complex and long patient intake process. • Changing, culturally-based preferences for how and where adults want to live and age. • Need for a consistent healthcare team to build strong relationships. • Fear of the healthcare system and delays in care.	• Identifying and facilitating part-time employment for older adults. • Streamlining patient intake processes. • Partnering with older adults to make decisions that affect their health and well-being, including living arrangements. • Establishing rapport and trust with older adults at all healthcare settings.
8. Program Funding *Funding for programs and services that support older adults, which, in their current state, are fragmented and siloed.*	
• Fragmented funding and services, and duplication of efforts. • Policies that tie programs and services to short-term or one-time funding. • Payment, reimbursement, and insurance structures that discourage organizational collaboration.	• Educating funders about the range of services and resources that older adults need to improve their health and well-being. • Building services into existing program budgets rather than rely on short-term grant funding. • Funding cross-sector initiatives that provide services and programs rather than recreating them in silos.
7. Workforce Development *Supporting and expanding the people who are at the front line and at the heart of the healthcare and public health systems. Significant workforce shortages make the provision of care for all who need it difficult.*	

• Direct care worker shortages and high rates of turnover. • Few multilingual healthcare professionals • Burnout, moral injury, and lack of workforce support.	• Recruiting and retaining multilingual healthcare professionals. • Establishing career pathways for direct care workers, including professional development opportunities, long-term career pathways, and financial incentives.

Information from the interviews was used to create a pilot-ready care coordination framework designed to bridge identified gaps across sectors. The framework includes three primary drivers that were developed in the process of organizing the themes from the stakeholder interviews into categories. These are referred to as the *Three Keys*: 1.) What Matters, 2.) Supportive System Structures, and 3.) Financial Structures and Policy Landscape.

Together, they draw upon upstream and downstream disruptions to and facilitators of the cross-sector care continuum.[xiv] Downstream solutions focus on direct interaction with older adults or their caregivers to address proximal, individual problems, such as access to treatment for depression or discomfort, using telehealth for primary care visits. Whereas upstream interventions focus on indirect change affecting large population groups and more distal or contextual factors, such as ageism or insurance reimbursement policies, that either encourage or discourage healthy behavior that affects social, structural, and political determinants of health.[xv]

The *Three Keys* function across sectors at different levels of the system. The first key, "What Matters," aligns with downstream approaches and works to address the experience of older adults and caregivers and improve their care across the continuum. It builds upon the definition of "What Matters" from AFHS, defined as knowing and aligning care with each older adult's specific health outcome goals and care preferences, including, but not limited to, end-of-life care and across settings of care.[xvi] Health outcome goals relate to the values and activities that matter most to an individual, help motivate the individual to sustain and improve health, and could be impeded by a decline in health — for example, babysitting a grandchild, walking with friends in the morning, or volunteering in the community. The second key, "Supportive System Structures," includes midstream solutions, addressing the systems and processes that organizations and entities have the power to address. The third key, "Financial Structures and Policy Landscape," aligns with upstream approaches that change policies and the macro-environment conditions that affect organizations, communities, systems, and people. The framework and supportive tools – an implementation guide, workbook, journey maps, and driver diagram (see Figure 1) with change ideas and measures – provide guidance on how to operationalize the *Three Keys* framework. These resources can be found in Supplemental Digital Content Table A, available at https://online.fliphtml5.com/evmfl/iaqa and ihi.org.

The implementation guide walks readers through the *Three Keys*, illustrating essential actions to improve health for older adults across the care continuum using quality improvement and other methods. A description of each of these drivers of change and its components is followed by a

list of process measures and a table of associated change ideas, which are a catalyst to accelerate improvement. Some of the proposed change ideas may apply to individual organizations in public health or healthcare in their roles as part of the Age-Friendly Ecosystem, while others require partnering within, across, or beyond these sectors.

The workbook is designed to help prepare for, test, and implement the change ideas to improve care. It includes examples relevant for public health and healthcare cross-sector teams, including 1) federal, state, and local public health agencies as well as the governmental public health system and 2) healthcare systems such as hospitals, nursing homes, ambulatory care, or convenient care clinics. The workbook includes step-by-step recommendations to support cross-sector care coordination for older adults: 1) get started, 2) form a cross-sector team, 3) understand the current state, 4) set an aim, 5) measure improvement, and 6) sustain improvements.

Care journey maps are visual narratives depicting the multidimensional relationship between an individual and a service. The maps center on the experiences of older adults and their caregivers, showing the importance of assessing and acting on what matters to older adults and illustrating the complexity and impact of the current system. Qualitative data from the interviews were used to understand the current state and systems factors that were impeding quality, reliable care, and preventive services. The data was also used to establish the future state of the situation and how the public health and healthcare systems can improve care coordination.

Characteristics of the older adults and caregivers interviewed were combined to create three personas represented in the maps. There are three map sets, with six maps in total, representing personas with the following characteristics: 1) Latinx/Hispanic rural adult with diabetes and chronic health conditions, aged 75 years (Maps 1 & 2); 2) Black/African American urban adult with mental and behavioral health challenges, aged 65 years (Maps 3 & 4); and 3) white suburban adult with history of falls and mobility challenges, aged 80 years (Maps 5 & 6). Cross-sector teams can use care journey maps to address systemic factors by identifying issues in the current state maps and testing change ideas to improve the systems. Direct care providers can use the maps as a tool for dialogue with older adults and caregivers about their experience navigating services across the care continuum and to determine what matters most.

The driver diagram depicts primary, secondary, and tertiary drivers of improved coordinated care for older adults, which were derived from the qualitative interviews. Tertiary drivers (not depicted in Figure 1) provide detailed information on factors affecting coordinated care. Change ideas include specific actions, organized by secondary drivers, that cross-sector teams and direct care providers can take to improve coordinated care for older adults transitioning from acute care to community settings. Suggestions build on findings from the stakeholder interviews. Finally, a set of sample process measures, also organized by secondary drivers, and overall outcome measures can help cross-sector teams document progress.

Discussion

While this work has been modeled in Michigan, the work aims to ensure that all older adults can age in optimal health in a setting that is aligned with their wishes and within an equitable system that is supportive of cross-sector care coordination. This work serves as a blueprint that highlights the importance of qualitative results from interviews with stakeholders, especially those with lived experience, as a key input to inform the development of implementation tools for action and improvement. This process sought to understand factors affecting transitional care for older adults in Michigan through a series of interviews. Our questions focused on individuals' understanding of Age-Friendly Health Systems and Public Health Systems as well as their experience of barriers to and facilitators of better care coordination for older adults during transitions from acute care to community settings.

While some participants were unfamiliar with the term "age-friendly care," they were aligned on their understanding of barriers and solutions, which coalesced into three major drivers of change. This information yields a cross-sector care coordination framework defined by *Three Keys*. Secondary drivers of change are organized according to the three main drivers. Secondary themes with overlap between stakeholder groups included accessibility of care, adult-centered care, and workforce development. Drivers identified by older adults and caregivers only included affordability of care, care coordination and navigation, caregiver support, and culturally centered and equitable care. Themes from organizational leaders only included collaboration, communication, and program funding.

Interview findings on barriers to improved, coordinated care is supported by literature reviews similarly pointing, for example, to workforce shortages or limited staffing capabilities;[xviixviii] underutilization or inappropriate use of telehealth;[xix] affordability of care;[xx] poor communication and coordination of services among providers;[xxixxiixxiiixxivxxvxxvi] lack of information on services such as care pathways;[xxvii] limited staffing capacity and need for training;[xxviii] limited support for service users and carers to navigate and access the health and care system and availability of infrastructure to support and fund integrated care[xxix]; funding silos and competitive, short-term grants.[xxx]

Emergent themes on facilitating factors are also corroborated in the literature, with studies similarly documenting the need for care that matters to older adults, supportive systems, and financial structures.[xxxixxxiixxxiiixxxiv] A rapid scoping review of the literature on integrated care for older adults[xxxv] noted the following facilitating factors: connected service networks and effective referral systems; cooperation across care provider organizations and the integration of health and social care at the clinical level; empowerment of individuals to be involved in their own care; enhanced communication via integrated electronic record management; assigned case managers; and comprehensive multidisciplinary geriatric assessment to enable personalized care plans. Other more recent reviews point to geriatrics-based training of clinical and community providers;[xxxvixxxvii] collaborative, team-based models of care;[xxxviii] telehealth adaptations for older adults;[xxxix] centralized and open access to healthcare records;[xl] and improving active involvement of service users and care providers in care decisions.[xli]

While this resource does not focus on the implementation of specific strategies for ensuring continuity of care, it does provide both cross-sector teams and direct service providers a menu of options for determining care pathways most likely to support better health outcomes and ways of assessing associated individual and community-level outcomes. Moreover, this resource builds on and further operationalizes aspects of the Age-Friendly Ecosystem, drawing on evidence-based, age-friendly principles of healthcare systems[xlii] and best practices of age-friendly public health planning[xliii] to move the field from an "aspirational" to a "coordinated reality."[xliv] The resulting guidance for cross-sector care coordination attends to upstream and downstream challenges and solutions to promote better health and well-being transitioning from one care setting to another. Further, it illustrates the importance of how bridges, rather than silos, between sectors (e.g., healthcare, public health, community, education, employers) in the ecosystem are needed to address documented gaps in care.[xlv] An important next step will be to monitor and determine the feasibility and utility of the guide in practice. The goal is to test the validity of the guide and supplemental resources in practice with a small set of cross-sector improvement teams to demonstrate the impact on systems improvement and the health and well-being of older adults.

Implications for Policy and Practice

- Involving older adults, caregivers, and individuals at the front lines of care and services across sectors is vital to the development, design, and delivery of programs and initiatives.
- Healthy aging requires that all sectors collaborate through alignment in vision and scope to collectively support the health and well-being of older adults.
- The healthcare and public health sectors play a crucial role to ensure that policies, programs, and systems are in place to maximize health and well-being during transitions from acute care to community settings, and that equity is embedded across these systems.
- The *Three Keys* framework offers specific guidance on how practitioners working in healthcare and public health settings can work together in a coordinated effort to improve health outcomes.
- Adoption and implementation of the change ideas included in the toolkit will help move the US health system toward one that is high-quality, respectful, accessible, and equitable. However, policy changes are needed to support partnerships between public health, healthcare, and community-based stakeholders to address the broader needs of the growing older adult population.
- The development of a cross-sector care coordination framework may prove useful to champions in other sectors in the Age-Friendly Ecosystem who are interested in formalizing approaches to the co-creation of programming, policies, and systems.

Supplemental Digital Content

- The Three Keys to Cross-Sector Age-Friendly Care Implementation Guide & Workbook full set of materials https://online.fliphtml5.com/evmfl/iaqa/

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