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COMMENTARY

# Actualizing Better Health And Health Care For Older Adults

**ABSTRACT By 2030 more people in the United States will be older than age sixty-five than younger than age five. Our health care system is unprepared for the complexity of caring for a heterogenous population of older adults—a problem that has been magnified by the coronavirus disease 2019 (COVID-19) pandemic. Here, as part of the National Academy of Medicine's Vital Directions for Health and Health Care: Priorities for 2021 initiative, we identify six vital directions to improve the care and quality of life for all older Americans. The next administration must create an adequately prepared workforce; strengthen the role of public health; remediate disparities and inequities; develop, evaluate, and implement new approaches to care delivery; allocate resources to achieve patient-centered care and outcomes, including palliative and end-of-life care; and redesign the structure and financing of long-term services and supports. If these priorities are addressed proactively, an infrastructure can be created that promotes better health and equitable, goal-directed care that recognizes the preferences and needs of older adults.**

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In 2018 the US population ages sixty-five and older numbered 52.4 million, with older adults representing 15.6 percent of the population.[1] By 2030, 20 percent of Americans will be age sixty-five or older. The most striking aspect of this population is its heterogeneity. In 2017, 23 percent of older Americans were members of racial and ethnic populations, and this percentage will increase by an estimated 135 percent between 2017 and 2040, compared with 36 percent for the non-Hispanic White population.[2] And although stereotypes portray older people as frail, disengaged, and cognitively impaired, many are industrious, creative, and intelligent into the tenth decade of life.

Because of momentous advances in science and technology, the knowledge and skills exist to provide excellent preventive and clinical care to this cohort. What is now needed is the policy, and the will, to take collective action to ensure that all older adults are engaged in health promotion and disease prevention and receive equitable, person-centered, high-quality care. Effective policies are needed that can bridge the gaps between public health, health care, and other sectors of the economy, focusing on social determinants of health and preventive measures to reduce the burden of chronic disease while also providing person-centered care to those with serious illness. Online appendix exhibit A1 illustrates this approach.[3]

In 2016, as part of the National Academy of Medicine's Vital Directions for Health and Health Care initiative, an expert panel wrote a paper that provided guidance for preparing the nation for the realities of an aging population.[4] Since the publication of "Preparing for Better Health and Health Care for an Aging Population: A Vital Direction for Health and Health Care,"[5] emerging trends have included more personalized approaches to care; greater elicitation of goals and preferences from those receiving care;[6]

and growing sophistication in the use of electronic health records (EHRs) to identify risk, classify subpopulations, and direct appropriate interventions. Alternative payment models and Medicare Advantage have created flexibility that permit innovation in care delivery and promote more efficient and higher-quality health care. The CAPABLE (Community Aging in Place—Advancing Better Living for Elders) model is a good example of this flexibility: Section 1915 Medicaid home and community-based services waiver dollars are used for home repairs and in-home care that improves safety and health outcomes for older adults.[7]

Yet most older people remain insured under traditional fee-for-service Medicare, which incentivizes profit-generating services. Policy changes such as bundled, capitated, and other value-based payments are urgently needed to promote the delivery of care that addresses the social determinants of health, encompasses lifestyle modifications, recognizes the diversity of the older population, and provides needed services for elders with serious illnesses.

The 2016 Vital Directions authors expressed deep concerns regarding health care disparities, inequality, structural racism, and the resulting disproportionate risk for adverse outcomes among those who are disadvantaged and most at risk. In 2020 these concerns are even more grave, and they present an opportunity for renewed assessment and policy directions for addressing persistent issues. Further, the coronavirus disease 2019 (COVID-19) pandemic has exposed fundamental problems in the US health care system that specifically affect older people.

In this article, as part of the National Academy of Medicine's Vital Directions for Health and Health Care: Priorities for 2021 initiative, we identify six vital directions to improve the care and quality of life for all older Americans. The National Academy of Medicine invited this author group, from diverse professional backgrounds, to iteratively generate policy recommendations for the next administration. We provide the following agenda for policy makers to actualize better health and health care for older adults.

## Recommendations

**CREATE AN ADEQUATELY PREPARED WORKFORCE** The Health Resources and Services Administration (HRSA) and the Centers for Medicare and Medicaid Services (CMS) must strategically plan for and support the creation of a robust, qualified workforce across settings through a coordinated interdisciplinary approach that includes scholarships, loan forgiveness, and clinical internships, as well as efforts to train professionals and direct care workers who are already in the workforce.

**STRENGTHEN THE ROLE OF PUBLIC HEALTH** Congress and the administration should mobilize and fund the Centers for Disease Control and Prevention (CDC) and state and local health agencies to make healthy aging an essential component of public health. The Department of Health and Human Services (HHS) should ensure that public health efforts for older adults are aligned with those in the health care and community-level services sectors at local, state, and federal levels.

**REMEDIATE DISPARITIES AND INEQUITIES** The administration and Congress should support the establishment of a cross-agency, cross-secretariat committee to develop and implement policies and programs that eliminate the social, structural, and economic obstacles to the optimal health and well-being of older adults. Such interventions will require integration of federal, state, and local government agencies, as well as public health and community-based organizations to address the full spectrum of social determinants of health. In addition to a continued focus on social needs such as housing, food security, and transportation, new attention should be given to addressing social isolation among older adults.

**DEVELOP NEW APPROACHES TO CARE DELIVERY** Congress and CMS should work toward optimizing the balance in payment between remote and in-person care for older adults and should promote policies that ensure education and resources for the integration of telehealth into existing and new evidence-based practice models. Encouraging innovation and increasing access to EHRs for older adults and caregivers is important, as is increasing broadband access to all communities.

**ALLOCATE RESOURCES TO PALLIATIVE AND END-OF-LIFE CARE** Congress and the administration, including HHS and CMS, should expand access to and use of palliative care for older adults. Serious illness care, dementia care models, and other evidence-based programs that focus on improving quality of life, including end-of-life care, should be prioritized. Access to such programs should be based on need instead of being tied to prognostic estimates.

**REDESIGN LONG-TERM SERVICES AND SUPPORTS** Government entities including HHS, CMS, state Medicaid programs, the Administration for Community Living, and the CDC should test and adopt successful innovations and concomitant payment models to expand services to improve the quality of care in nursing homes and home and community-based services. Older adults should be able to choose whenever possi-

ble between aging in place and residing in an institutional setting.

Taken together, these recommendations call for a major reform of the current health-related systems and payment structures to create value, reduce waste, and better serve older adults. We next describe background and approaches for the six vital directions.

## Approaches To Change

**CREATE AN ADEQUATELY PREPARED WORKFORCE** An expanded and better-trained workforce for older adults is needed. In 2008 a report from the Institute of Medicine[8] proposed a three-pronged approach to strengthening the health-related workforce. Recommendations included enhancing the competence of all providers who deliver health care, increasing the recruitment and retention of geriatrics specialists, and redesigning models of care for more efficient deployment of the existing workforce. As a result, the HRSA-funded Geriatric Education Centers, established to improve competence in geriatric care, evolved into the Geriatrics Workforce Enhancement Program, which maximizes patient and family engagement.[9]

However, the strategy of training more geriatrics specialists from all disciplines has been a failure, with barely any change from the 2008 report.[10,11] The incentives and potential rewards of professional careers focused on the care of older adults have been insufficient to attract graduates, who are frequently burdened with substantial debt and are often uncomfortable with the complexity of care for this population. Scope of practice and compensation parity debates are ongoing.

Creative education and training approaches such as simulation and virtual learning can accelerate mastery of geriatric care principles for all students. It is essential to educate, support, and monitor all care providers using these same geriatric care principles and strategies, not just providers choosing a career in geriatrics.

Since the publication of the 2008 Institute of Medicine report,[8] new models of care have been created for conditions that affect those with dementia,[12] falls,[13] and depression.[14] The Institute for Healthcare Improvement's Age-Friendly Health Systems initiative is an example of system reform and is now in present all fifty states and several countries. The model promotes the adoption and spread of geriatric care principles through reliable use of evidence-based best practices in a "4Ms" framework (what matters, mentation, medication, and mobility). This approach has resulted in improved care, reduced harm, and fewer low-quality services across the entire care spectrum.[15,16] The 4Ms framework has been adopted by the HRSA Geriatrics Workforce Enhancement Program and should be embedded into other federal training programs for health care professionals.[17]

**STRENGTHEN THE ROLE OF PUBLIC HEALTH** Historically, older adults have benefited from advancements in public health such as vaccination programs and smoking cessation, but public health has not focused on aging services or programs. However, recent work directed at creating age-friendly public health systems (in coordination with the Age-Friendly Health Systems movement) that leverages public health skills and capacity is gaining momentum. Attention to the need for an age-friendly public health system recognizes aging as a core public health responsibility and leverages the system's skills and capacities to improve the health and well-being of older adults.[18] Age-friendly public health systems create the conditions at the national, state, and community levels that older adults need to live safely, healthfully, and productively. Programs and policies that ensure access to fresh food, exercise, and social engagement are examples. A 2017 pilot program in Florida, led by Trust for America's Health, showed the potential of these systems.[19] Among the core elements of this work are targeted data collection and analysis; adaptation of existing programs, including emergency preparedness, to meet the needs of older adults; and improved coordination and collaboration with Area Agencies on Aging and key health care providers. A follow-up call for additional state pilot programs has garnered significant interest, and standards are being developed for certification. A proposal to expand this pilot work has been introduced in Congress with bipartisan support. Federal funds would support grants to states and localities, create a Healthy Aging program at the CDC, and provide the requisite technical assistance.

**REMEDIATE DISPARITIES AND INEQUITIES** The World Health Organization defines *social determinants of health* as "the conditions in which people are born, grow, live, work and age... shaped by the distribution of money, power and resources at global, national and local levels."[20] Harmful social determinants of health can have lifelong impacts, exposing those affected to higher risks of morbidity, mortality, suffering, and economic costs. Black older adults who grew up during the Jim Crow era and who have endured structural and systemic racism throughout their lives are likely to be at greater risk for poor health and have fewer opportunities to achieve optimal well-being.[21,22] The COVID-19 pandemic caused the greatest harm in communities with poor conditions for health.[23]

CMS expanded coverage via Medicare Advantage plans to include benefits that relate to the social determinants of health, such as air conditioners for people with asthma, healthy groceries for people on medically prescribed diets, and home-delivered meals for people who are immunocompromised.[24] This type of coverage should be expanded for all older adults who are dually eligible for Medicare and Medicaid. Efforts to promote racial equity should include ensuring access to comprehensive health insurance and high-quality care, implementing programs and policies such as criminal justice reform, and facilitating meaningful partnerships with community-based organizations that serve people of color.

Social isolation is caused or exacerbated by social, economic, and environmental conditions. Isolation is an underappreciated health concern that is associated with an increased risk for premature mortality that is comparable to that of smoking, obesity, and physical inactivity. Up to 24 percent of community-dwelling older adults experience social isolation, and up to 43 percent of adults ages sixty-five and older report being lonely. Difficult and abusive relationships also are known to increase isolation, loneliness, and elder mistreatment.[25]

Referrals to agencies that provide in-home support can help address social isolation and loneliness. Isolation can be reduced or prevented by the development of innovative housing options, recreational and employment opportunities, and improved transportation and public safety measures.[26] The secretary of housing and urban development should be directed to fund housing models that promote equity and address the social determinants of health.

**DEVELOP NEW APPROACHES TO CARE DELIVERY** Policy changes to Medicare and Medicaid during the COVID-19 pandemic have reduced barriers to telehealth access and promoted its use.[27] Professional medical societies have endorsed telehealth, whereas telehealth experts have documented improved patient health outcomes.[28] However, with the growth of telehealth and other virtual services, technology must be continuously adapted to the needs and capabilities of all older adults. Advances in telehealth and technology should be promoted through regulatory action, payment incentives, federal and state demonstration projects, and the development of public-private partnerships.

The lack of access to technology, low digital health literacy, and design barriers in patient portals and apps have disproportionately affected older adults, especially those in underserved communities.[29] The National Institute on Aging has funded research that documents the effectiveness of the use of telehealth for dementia care, which should be adopted broadly.[30]

Approaches to optimizing telehealth should include efforts outside health care (for example, expanding broadband access and including older adults and diverse populations[31] when designing and testing new portals and apps) and within health care (for example, routinely asking older adults about their access to technology, incorporating sociodemographic and literacy metrics, and increasing patients' and caregivers' access to EHRs). For people with cognitive, sensory, and functional impairments, adaptive solutions such as remote cognitive assessment to detect change and video monitoring to assist with safe medication management have been valuable clinical tools.

Although telehealth may improve care coordination and access by connecting community-based organizations with health care systems, barriers remain, including privacy concerns related to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 as well as lack of infrastructure, interoperability, and expertise at these organizations.

OpenNotes, a movement aimed at ensuring that all patients can access and edit their care records as needed, encourages communication and transparency among older adults, families, and providers through shared access to notes.[32] Open access to health care records was mandated in the 21st Century Cures Act of 2016.[33] The next priority should be to pass federal legislation allowing patients and authorized family caregivers to modify and edit their own health records to improve care and outcomes.

Access to tools such as Zoom videoconferencing and FaceTime have been shown to be helpful in reducing social isolation and improving mobility and mood.[34,35] Such technologies have been shown, for example, to decrease agitation and behavioral problems such as excessive vocalization in older adults with dementia. Remote sensors may improve safety and reduce falls in people with dementia.[36] The advent of robotics, including robotic pets for therapy, holds promise for improving care for older adults.[37]

Technology can improve workflow in nursing homes and other institutional settings (for example, delivering linens and patient food trays could be automated), allowing the workforce to focus on tasks that require a human touch.[38]

**ALLOCATE RESOURCES TO PALLIATIVE AND END-OF-LIFE CARE** Many older adults are living with serious illness, defined as "a health condition that carries a high risk of mortality AND either negatively impacts a person's daily function or quality of life, OR excessively strains their caregivers."[39] Only a small proportion of older

adults report that they have taken steps to plan for serious illness.[40] Most will live for years with their illnesses, resulting in a high burden of physical and psychological distress, functional dependence, poor quality of life, high acute care use, loss of savings, and caregiver distress. Members of racial and ethnic minority groups are disproportionately affected.[41,42]

Because cures are rarely possible for such people, the approach should shift from disease-oriented care to patient-centered care, defined as "respectful of and responsive to individual patient preferences, needs, and values[,]...ensuring that patient values guide all clinical decisions."[43] Such care elicits and seeks to meet individual health goals[5,44] and priorities[45,46] across a variety of dimensions (for example, symptoms, physical functional status, and social and role functions).

Palliative care is an evidence-based model that improves outcomes for people with serious illness, but it is underused in many regions of the country, with generally poorer access in community-based settings and for some racial/ethnic minority groups.[47] Additional efforts are needed to expand access to and use of these services across settings and throughout the course of serious illness, regardless of prognosis. The National Academy for State Health Policy has documented improved care and reduced unnecessary costs for people with serious illness who used palliative care.[48]

In addition to expanded access to palliative care specialists, older adults need front-line clinicians with adequate training in "primary palliative care skills" with a focus on communication and symptom management; all front-line clinicians should receive training in these skills.[49] Education, policies, and initiatives should be designed and evaluated to ensure equitable access to palliative care for diverse populations of older adults living with serious illness.

Older adults with serious illness are at greatest risk for problems with care coordination across health systems. Multiple care transitions can lead to medication errors, lack of follow-up care and referrals to necessary services, and disruptions in care planning and treatment, resulting in poor care and often harm. Such fragmented care can be mitigated by established transitional care approaches, use of advance directives, and honoring older adults' wishes for end-of-life care.[50,51]

**REDESIGN LONG-TERM SERVICES AND SUPPORTS** The US health care system fails to adequately support the long-term care workforce. At this time, nursing home staff and the in-home paid caregiver workforce, which is predominantly composed of people of color, are paid low wages with poor or no job benefits.[52]

It is time to redesign long-term care to facilitate older adults' remaining at home and aging in place, whenever possible, and to create better options for residential long-term care. Such reform will require new models that match services with the needs of specific patient groups, such as dementia facilities that are staffed by people trained to provide that care. Postacute rehabilitation care could be provided in the acute care setting, decreasing excess transitions of care and providing better care continuity. Reimbursement would need to be appropriately adjusted.

In the summer of 2020 CMS commissioned an expert panel to review why nursing homes were so disproportionately affected by the COVID-19 pandemic and to make recommendations for the future.[53] The panel called for increasing organizational capacity to improve safety and quality in nursing homes and developed twenty-seven recommendations including reexamination of infection control practices, staffing, and the physical design of facilities. Potential reforms include increased regulation around infection control, expanded availability of telemedicine visits, and increased on-site treatment of minor ailments in congregate settings. The National Academies are currently undertaking a study on safety and quality in nursing homes, which can build on the expert panel's recommendations.

Community-based long-term care will also need new models and financing to bring community-based organizations and health systems together to provide comprehensive care, particularly for people who are frail and have functional dependencies.

## Summary

Dramatic changes are needed in the US policy agenda to address the health and well-being of the growing older adult population. We propose a concerted, coordinated effort to advance six vital directions. Despite long-standing barriers to their adoption, the next administration and Congress—in partnership with state and local government entities—should tackle them with new vigor.

The next administration and Congress should articulate and establish clear priorities and provide relentless federal leadership to enact the necessary regulatory and legislative change. Early action is needed to strengthen the workforce to facilitate the coordination of care across all settings. Scope-of-practice arguments and payment thresholds will be obstacles but can be overcome. Other early initiatives are needed to incentivize public-private partnerships to accel-

erate technology solutions, bolster efforts to integrate Medicare and Medicaid financing for dually eligible older adults, and advance legislation and funding for healthy aging programming at the CDC and other federal and state agencies.

The current fragmentation of care, disregard for prevention, and disparate approaches to care can be resolved. It will take a willingness to work across traditional silos, a commitment to prolonging optimal health and independence, the restructuring of financing, and unwavering support for person-centered care. The changes will not come easily. But the burgeoning demographics and the critical needs of the older adult population make the challenge urgent and compelling. ■

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