

Collaborating for Healthy Aging: Innovations from Three Communities

Executive Summary

Public health and aging services have historically operated in silos due to separate funding streams, governance structures, and mandates. However, the rapid growth of the older adult population highlights the urgent need for cross-sector collaboration to support healthy aging, reduce disparities, and improve outcomes for older adults and caregivers. Coordinated approaches can enhance equitable access to services. Through the Age-Friendly Public Health Systems (AFPHS) movement, Trust for America's Health (TFAH) has advanced efforts to integrate healthy aging into public health practice and align with sectors serving older adults.

These three case studies showcase cross-sector collaborations that demonstrate successful integration between public health and aging services: a state-level initiative in Wisconsin and local initiatives in Riverside County, California, and Michigan. Findings from these case studies highlight key strategies for advancing collaboration. In Wisconsin, aligning aging services within the Division of Public Health supported a life-course and partnership-driven approach. Riverside County developed a service delivery model that improved

coordination, communication, and access through cross-agency collaboration and data sharing. In Michigan, partnerships between an Area Agency on Aging and local health departments expanded resources and leveraged complementary strengths.

These examples demonstrate that intentional cross-sector collaboration can break down silos, strengthen systems, and advance more equitable and coordinated approaches to supporting older adults.

The Critical Partnerships between Public Health and Aging Services

Historically, the public health and aging services sectors have operated in silos, shaped by separate funding streams and mandates, but both aim to improve the health of people in their communities. Public health brings expertise in data collection, surveillance, health promotion, prevention, and systems-level planning. When these strengths are paired with the aging sector's deep understanding of the needs, preferences, and lived experiences of older adults, communities can develop and implement more responsive and equitable programs. Partnerships between public health and aging systems also enable more efficient use of resources and create opportunities for innovative, cross-cutting initiatives. Together, these sectors can expand the reach of evidence-based programs and align strategic plans that support people across the lifespan. By breaking down silos and collaborating intentionally, public health and aging partners can amplify each other's impact and ensure that

older adults and their caregivers receive the support they need to thrive.

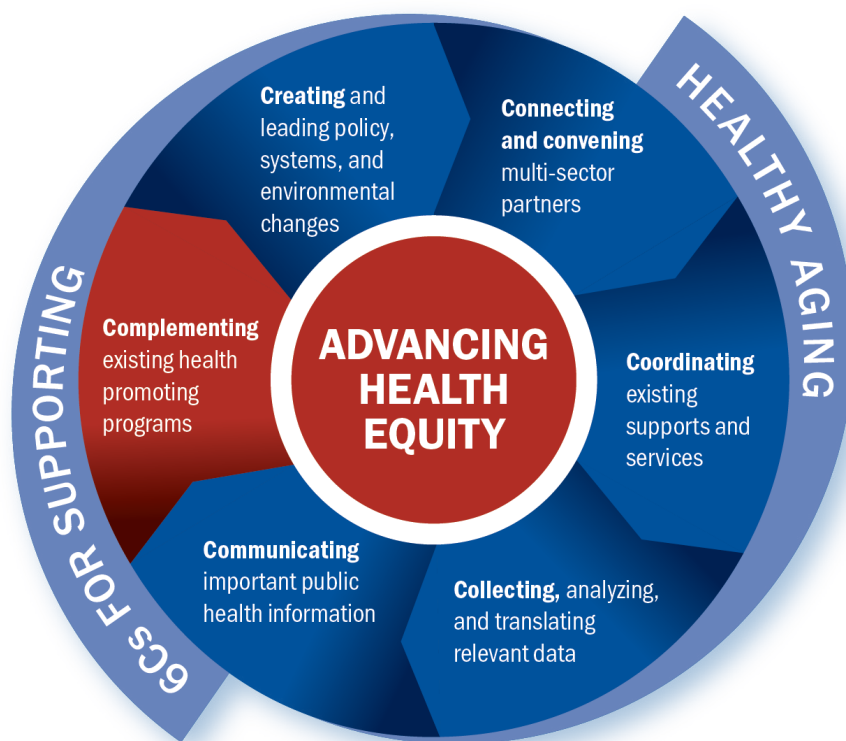
With the rapid growth of the older adult population, collaboration between these sectors is more critical than ever. Coordinated efforts can improve community conditions for healthy aging, address health disparities among older adults, and ensure that older adults and caregivers thrive. Collaboration across sectors is a powerful and efficient strategy to ensure equitable access to services and resources for older adults. Through the Age-Friendly Public Health Systems (AFPHS) movement, Trust for America's Health (TFAH) has been leading the effort to make healthy aging a priority within the public health sector. To highlight the importance and impact of collaboration between the public health and aging sectors, we explored three collaborations—one state-level initiative and two local-level initiatives.

The AFPHS 6Cs Framework as an Organizing Tool for Public Health Roles in Healthy Aging

Since 2017, TFAH has developed, modified, and continues to apply a framework that delineates the roles public health can play to promote older adult health and well-being. The tenets of the 6Cs framework are:

1. Creating and leading policy, systems, and environmental changes to improve older adult health and well-being.
2. Connecting and convening multi-sector partners to address the health and social needs of older adults through collective impact approaches focused on the social determinants of health.
3. 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.
4. 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.
5. 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.
6. Complementing existing health promoting programs to ensure they are adequately meeting the needs of older adults.

The 6Cs framework provides guidance for health departments on how to expand existing programs and explore new ways to address the needs of older adults in their jurisdictions. This report uses the 6Cs framework to describe the three public health and aging sector partnerships noted above.



Aging and Public Health: Wisconsin's Vision for Aging Well

History and Structure

This collaboration demonstrates how the State of Wisconsin supports older adults through its unique structure and related services. The state primarily serves older adults through its Department of Health Services (DHS), which houses the Division of Public Health (DPH). The DPH includes eight agencies, including the Bureau of Aging and Disability Resources (BADR), the Bureau of Operations, Office of Health Informatics, the Bureau of Communicable Diseases, the Office of Preparedness and Emergency Health Care, the Office of Policy and Practice Alignment, the Bureau of Community Health Promotion, and the Bureau of Environment and Occupational Health. Prior to 2016, aging and disability programs were part of a division that included Medicaid long-term care programs—not the BADR. This configuration offered sufficient funding for the work, but only served three percent of Wisconsin adults aged 60 and older. The BADR served all individuals 60 and over as well as those with disabilities, but with fewer and limited resources compared to the long-term care division. Due to a new budget initiative in 2016, DHS leadership made the strategic decision to move the BADR to DPH and combine all the Medicaid programs under one umbrella.

This structure allows the aging services agency to have greater visibility within the DHS and be better aligned with public health goals. Restructuring improved program delivery and the development of policies that more effectively support both public health and aging services programs. The benefits of integration also include stronger collaboration and cross-disciplinary learning; a more holistic, life course approach to public health and addressing social determinants of health; and a shift from a focus on compliance to developing partnership-oriented approaches. Leaders in BADR and DPH began to think about how to align departmental goals and priorities to better serve older adults and people with disabilities. Becoming part of the DPH allows BADR to become part of program planning discussions across all divisions.

For example, Wisconsin is currently developing a Multisector Plan on Aging (MPA) to create a cross-system vision and framework for aging. MPAs are 10-year blueprints that guide the development of a coordinated system for restructuring state and local policies to better support older adults and caregivers. The Wisconsin MPA will be designed to integrate public health more intentionally into statewide aging strategies, setting the stage for more coordinated and comprehensive efforts.

Wisconsin: Highlighting Structural Change through the 6Cs Framework

Creating and leading policy, systems, and environmental changes

Systems transformation can pose potential challenges and pushback from affected parties, so strong agency leadership is crucial to navigate the restructuring process. DHS leadership developed a robust communications plan to support the transition, providing staff with weekly updates that explained the reasons for the changes and what the process would entail. The internal messaging emphasized how the restructuring aligned with DHS's vision and mission as well as the 10 Essential Public Health Services, the benefits of working together instead of across agencies, and that integrating BADR into DPH would ultimately strengthen the delivery of services and programs for Wisconsin's older adults. To foster collaboration, the BADR Director met with all DPH directors to build relationships, better understand their roles, and identify opportunities for partnership. Leadership from both BADR and DPH also began meeting regularly at the start of the restructuring to establish trust and strengthen working relationships.

Connecting and convening multi-sector partners

The planning process for Wisconsin's state health improvement plan (SHIP) created an opportunity for the agency to convene multi-sector partners. When BADR moved to DPH, its staff became part of the planning process for the SHIP, which had previously not included the aging network. Aging sector partners are now actively involved in local discussions, contributing valuable perspectives that now appear throughout the SHIP's goals and strategies. BADR uses SHIP priorities to guide its own activities, aligning many of its programs with statewide objectives. BADR also participates in workgroups related to SHIP. This led to systems-level actions to which everyone can contribute. It also ensured that these efforts are actionable and systems-focused.

The Wisconsin State Health Assessment process includes community conversations with older adults and people with disabilities. During these conversations, older adults and people with disabilities expressed views that were consistent with other age groups, including concerns about the environment, housing, transportation, and social isolation. These issues were ultimately reflected in the five priority areas of the state's improvement plan: 1) social and community conditions; 2) physical, mental and systemic safety; 3) person- and community-centered care; 4) social connectedness and belonging; and 5) mental and emotional health and well-being. For example, a workgroup was formed

to address the housing priority with partners who focused on the unhoused population. The formation of this group fostered better internal coordination across departments and divisions, and across the state. This group also raised awareness of homelessness and housing vulnerability among the older adult population in state-level policy.

Coordinating existing supports and services

The new DPH/BADR alignment proved crucial to enable a more coordinated COVID-19 response that leveraged existing resources across the agency. With this structure, BADR was at the table from the outset of the pandemic, ensuring that the needs of older adults were understood and addressed throughout the public health emergency response. This alignment also allowed BADR to share resources and mobilize the aging network to support outreach and vaccine distribution efforts to older adults, including those who needed vaccines administered in their homes. As a result, emergency responses were faster and more effective. This collaborative approach has continued, with ongoing training on accessibility and joint planning for future emergencies.

One key shift influencing the success of the organizational structure was the expansion of public health's traditional focuses to include older adults as an ongoing priority, similar to ongoing work in maternal and child health. BADR's advocacy efforts were strengthened by new partnerships with networks across the public health, aging, and disability sectors. These partnerships fostered unified messaging to ensure that the voices of older adults and people with disabilities are consistently represented in policy discussions. This level of collaboration is also evident among the local departments of health and local aging services providers, which now jointly apply for grants and work collaboratively on age-friendly and dementia-friendly initiatives.

Communicating important public health information

BADR partnered with the National Center to Reframe Aging to launch a new initiative aimed at reshaping public narratives and perceptions of aging. BADR has long recognized ageism and ableism as root causes of systemic barriers for older adults and prioritized the dismantling of the stigmas related to these perspectives in their work, and this initiative builds on those existing goals. This effort includes intensive training cohorts, statewide trainings for public health communicators, and the involvement of public health staff in reframing and messaging efforts.

Collecting, analyzing, and translating relevant and robust data

Staff were able to better access and use data via the DPH's Office of Health Informatics as a result of integrating BADR

within the DPH. This access enabled the use of existing public health data on older adults, identification of data gaps, and evaluation support for aging-related programs. Improved data access has enhanced planning efforts and strengthened policy advocacy around issues that impact older adults.

Complementing existing health promoting programs

DPH began leading systems-level initiatives on dementia in 2013. Since then, it has received two federal grants to advance dementia-related work, building on the state's longstanding dementia plan established in 2014. This funding is through the Building Our Largest Dementia Infrastructure (BOLD) grant, for which awardees are tasked with developing strategies to expand and strengthen prevention and response to Alzheimer's disease and related dementias within their jurisdictions.

In 2019, BADR served on a steering committee and contributed to the development of a state-level dementia plan that established nine goals. The first goal focused on increasing understanding of and reducing stigma associated with a dementia diagnosis. To advance this goal, BADR leveraged BOLD grant funding to create a statewide public awareness campaign with the Alzheimer's Association. This campaign highlighted available services and resources to support people living with dementia and their caregivers. DPH also partners with multiple organizations to develop programs and curricula, including the Aging and Disability Resource Center in Dane County, the University of Wisconsin Center for Interprofessional Education and Practice, the Wisconsin Department of Public Instruction, the Great Lakes Native American Elders Association, and the Hispanic Health Resource Center at ProHealth Care.

Guidance for Other States

While this system-level merger sparked innovation and collaboration, this structure is not required for successful integration of healthy aging into public health efforts. The progress in Wisconsin hinged on a willingness among agency staff to engage in partnerships with a focus on strengthening coordination across organizations and sectors. The first step in building effective partnerships is to identify common goals and opportunities for sharing the workload. Understanding where agency goals align and what each agency can contribute will lead to more productive and sustainable collaboration. The collaboration should be bi-directional and requires consideration of how partners can be helpful to each other. Cross-sector collaboration can be strengthened through a variety of strategies. For example, applying an aging lens across public health focus areas such as tobacco control, nutrition, and caregiving can facilitate

the development of policies and programs that address the needs of all people regardless of age.

Another strategy is to promote a family- and community-centered approach that recognizes the interconnected well-being of individuals and the broader community. For example, older adults may live in multigenerational households or closely connected communities, where challenges such as food insecurity or housing instability often affect multiple family members, not just one individual.

In many cases, these relationships are reciprocal—children may benefit from the care and support of grandparents, while older adults may also receive support from younger

family members. Recognizing these dynamics can help inform more effective and inclusive interventions.

Cross-sector partners can work together to address shared social determinants of health—such as housing, transportation, and caregiving infrastructure—which are critical to achieving long-term, equitable outcomes. Overall, the structural integration of BADR within DPH at the Wisconsin Department of Health Services has advanced innovation and strengthened partnerships by elevating the needs of older adults and people with disabilities across systems. This approach has fostered a more coordinated and effective public health and human services framework—one that supports individuals throughout the life course.

RivCoOne: A Coordinated Approach to Providing Access to Resources in Riverside County, California

History and Structure

Riverside County, California (Riverside) is home to about 366,000 residents aged 65 or older. The local government provides access to health care coverage, temporary financial assistance, employment programs and training, and services that protect children and adults from abuse and neglect. The county has 40 different governmental departments, each having its own approach to providing services, including the Office on Aging. Historically, services for older adults were provided by multiple agencies, so referrals and follow-ups were fragmented and many residents had unmet needs that went undetected.

For example, an older woman with diabetes might visit a local clinic to assess her medication management. However, if she also suffered from loneliness, there would be no way to track her mental condition or even trigger a referral from the clinic to a mental health provider. This inefficient system of services led the county to explore how a single point of access with coordinated referrals and electronic tracking of services could better serve their residents. Now known as RivCoOne, the resulting model focuses on coordinating services and sharing data among county partners to promote more integrated and enhanced care.

Riverside County, California: Highlighting Structural Change through the 6Cs Framework

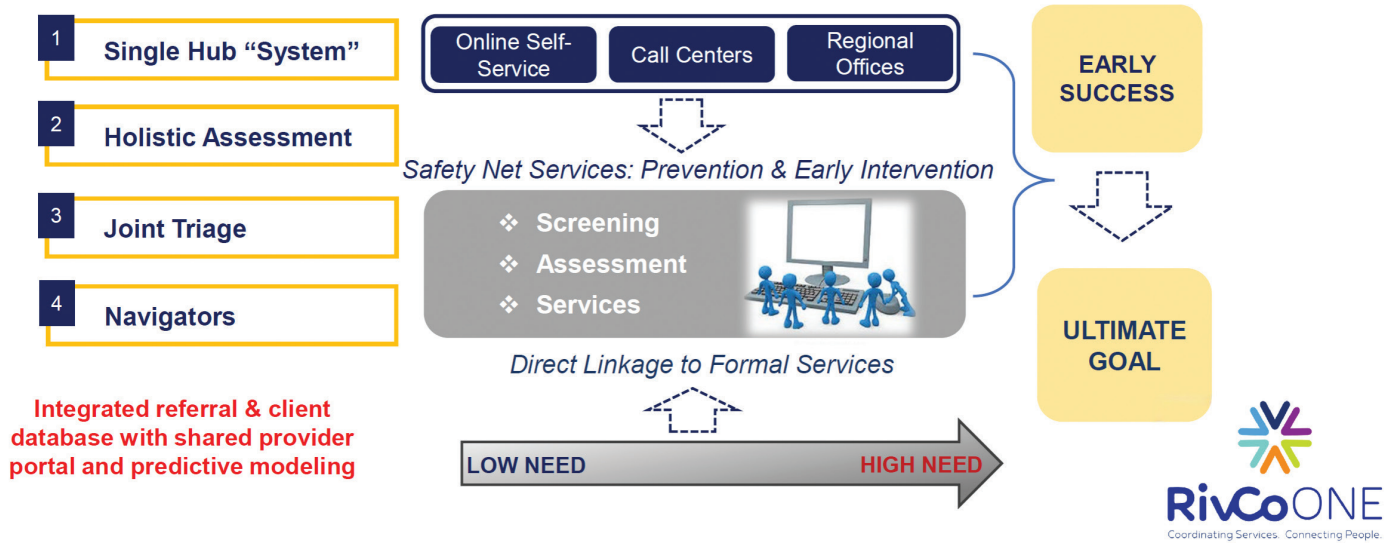
Creating and leading policy, systems, and environmental changes

In 2021, the Riverside County Board of Supervisors jumpstarted systems change by adopting Resolution 2021-

189[K4]. This resolution called for the development of an integrated and comprehensive county health and human services system through a coordinated care model and ensured funding to support the system changes. The goals of the integrated care model, as stated by the resolution, are to 1) strengthen prevention and earlier intervention services, and 2) improve service experience for Riverside County residents with complex needs. The vision of this model was to create a single point of access for residents, supported by holistic health assessments and a more coordinated approach to care navigation. The initiative is very similar to a “no wrong door” approach, which enables residents to access multiple services from any point of entry.

The implementation of the coordinated care model has proved valuable for county residents. For example, when Mr. Kipp, a 77-year-old veteran, contacted Riverside County’s Office on Aging call center in need of assistance navigating health insurance programs, the system enabled the identification of his additional need for housing support. Mr. Kipp’s needs were triaged, resulting in an appointment at one of the county’s pilot integration sites, where he completed an assessment and provided consent for service referrals. After the assessment, Mr. Kipp was linked to the Department of Public Social Services, Veterans Services, and Community Action Partnership, where he received application assistance for both health insurance and affordable housing.

HOW: Single Point of Access & Coordinated Wraparound Services



To sustain and scale the model, Riverside County Government is leveraging a \$3 million investment to establish an Office of Service Integration. The Office of Service Integration at the Riverside County Executive Office is leading the integrated services effort. This leadership team includes the director of public health and a public health officer from the Riverside University Health System. This office oversees staffing, data-sharing agreements, HIPAA compliance, and process improvements. The development of a new office to lead the integrated services approach is a strong example of leading systems change.

Connecting and convening multi-sector partners

In addition to engaging departments across Riverside County Government, including the department of health, several partner organizations were brought into the initiative to further streamline services and ensure efficiency. Initial partners included the Probation Department, County of Riverside Veterans Services, Housing and Workforce Solutions, the Children & Family Commission, the Office on Aging, and the California Mental Health Services Authority. This highlights the breadth of potential collaborations by connecting and convening diverse partners to build a more coordinated and responsive system of support.

Coordinating existing supports and services

To coordinate across health and social services and further help residents, Riverside County established Family Resource Centers and is investing in community health workers (CHWs). CHWs play crucial roles in connecting clients to resources, addressing health and social needs, and bridging cultural

and systemic gaps. As of 2022, California's Medicaid program (Medi-Cal) allows for reimbursement of CHW services. Riverside County is building a CHW Hub to centralize training, billing, and integration across departments. Riverside hopes the CHW model will also help provide a better connection between public health and aging services and older adult residents.

Riverside County piloted the CHW model at a local community health center, where more than 1,300 clients were connected to essential services such as Medi-Cal, CalFresh (California's Supplemental Nutrition Assistance Program), housing and transportation support, behavioral health care, and legal aid. Preliminary results show not only improved access to services but also upward trends in Whole Person Health Scores (WPHS), indicating measurable improvement in health and well-being. Clients also reported positive navigation experiences and easier coordination of services. The clinic was located within a site that also housed a dentist, grocery store, and behavioral health provider.

Riverside County's early success demonstrates the promise of a whole-person, integrated approach to health and human services. By combining innovative tools like the WPHS, leveraging the skills of CHWs, and reimagining service delivery around the individual rather than the program, the county is laying a foundation for a more efficient, equitable, and person-centered system. Continued focus on sustainable funding, workforce development, and cross-agency collaboration will be essential to fully realize this vision and improve the lives of residents across the county.

Collecting, analyzing, and translating relevant and robust data

At the core of the RivCoOne initiative is the Whole Person Health Score (WPHS), a screening tool that provides a six-letter score capturing physical health, emotional well-being, socioeconomics, lifestyle factors, and resource needs. Designed for self-administration, the WPHS allows providers to track changes in individual and community health over time and to target interventions more effectively.

The database is funded by the Office of Aging and tracks service referrals and the actions taken by the department to which the resident was referred. The information collected from the tool populates a database that allows departments to track when a resident interacts with a service supported by one of the county departments. This resource reduces duplicative intake processes across 20 agencies. The tool was originally used as part of California's 211 system (California's phone-based health and services referral line). The Office of Public Social Services used the same template to create this new tool. Database utilization statistics are incorporated into staff performance evaluations, helping to ensure consistent

use and long-term sustainability of the tool. Only clients' basic information is collected to ensure HIPAA compliance.

Guidance for Other States

Strong leadership and governance are essential to any initiative's success. Having a champion in a county leadership position, the County Executive Officer in this case, was helpful in getting the initiative started and ensuring continuous support. Finding agency partners already committed to enhancing coordination of services in the county was also important. The Riverside County Board of Supervisors allocates \$3 million annually to this project, and the County Executive Officer has made service integration a top priority.

Riverside County is now assessing the potential for its model to inform statewide efforts, emphasizing long-term sustainability, cultural transformation, and deeper systems alignment. Ongoing collaboration with Inland Empire Health Plan, the county's largest managed care organization, aims to broaden use of the WPHS tool across departments and community partners.

Building Bridges: Integrating Aging Services and Public Health in Michigan

History and Structure

The collaboration between public health and aging in this Michigan region arose primarily due to the physical proximity of the key partners. The service area managed by three local health departments – Branch, Hillsdale, and St. Joseph County Community Health Agency – spans two different AAA regions. One region, served by WellWise Services AAA, includes Hillsdale, Jackson, and Lenawee counties, while Branch and St. Joseph counties fall within the Area Agency on Aging 3C (AAA 3C) service area. The AAA 3C is housed within the St. Joseph Community Health Agency and operates as part of county government. The directors of AAA 3C and WellWise Services AAA are colleagues and decided to apply for funding to support public health efforts through the Michigan Department of Health and Human Services. Navigating this application process together enabled these aging services partners to strengthen ties with their local health departments and gave the public health partners a deeper understanding of the need to coordinate with AAAs that have greater expertise with older adults, adults with disabilities, and caregivers.

WellWise Services AAA (WellWise Services) has been serving the communities of Hillsdale, Jackson, and Lenawee counties since 1974. Their services are wide-ranging and include Connection Cafes designed to help people meet, Friendly

Reassurance calls to homebound older adults, home and community-based services, home safety assessments, Medicare counseling, and Community Transition Services to help nursing home residents return to their homes.

The local health departments serving these counties provide typical public health services, such as immunizations, emergency preparedness and response, health screenings, and health education. For WellWise Services, working with the departments of health solidified the partnership between county health agencies and the AAA network. This ensured that older adults, adults with disabilities, and caregivers to both groups are prioritized when creating and administering programs.

Wisconsin: Highlighting Structural Change through the 6Cs Framework

Creating and leading policy, systems, and environmental changes

Community-level services are the front line of health for all, including older adults. As noted in the Riverside collaboration example, fragmentation of services can hinder access to the full provision of those services. WellWise Services has only informally collaborated with local health departments in the past. Recognizing that referral systems are crucial to the successful delivery of community health services, WellWise Services and the three local health departments in Michigan

developed a system to provide multiple accessible pathways for people to find services. Using funding that WellWise Services received from an Age-Friendly Health Systems grant allowed them to formalize their relationship. This resulted in older adults having expanded access to services, and WellWise Services being able to educate front-line public health staff about AAA services. The funding they received allowed them to conduct a community survey to receive input on the programs and services that older adults need. To further support this partnership, a Community Health Specialist (CHS) was created at WellWise Services to coordinate activities between WellWise Services AAA, the Branch-St. Joseph AAA, and Branch Hillsdale St. Joseph (BHSJ) County Community Health Agency.

Connecting and convening multi-sector partners

During the COVID-19 pandemic, WellWise Services's knowledge about the older adults in the community informed their leading role in the administration of vaccine administration in coordination with the local health department. WellWise Services coordinated vaccine appointments for older adults, which helped formalize relationships with the local health departments. Additional key partners for this effort included pharmacies, aging-sector partners, and community-based organizations in the three-county service area. This collaboration fostered ongoing consultation and built sustainable partnerships.

Joint vaccine clinics have also been developed to avoid duplication of efforts. USAging, the national organization that represents and supports the network of AAAs and Title VI Native American Aging Programs, provided vaccine grant funding to AAAs to develop vaccine distribution programs in partnership with public health. Receiving this funding facilitated additional coordination between WellWise Services and the health departments. In addition, data-sharing protocols were established, allowing the use of health department data specifically on older adults to strengthen grant applications.

Coordinating existing supports and services

Coordinating services provided across agencies is important to avoid duplication, especially when funds are limited. BHSJ collaborated with WellWise Services and AAA3C to review emergency management procedures to ensure that older adults were considered. In addition, local health departments in the counties now provide real-time resource information to WellWise Services staff during extreme weather events, which significantly reduces the time needed to find available support.

The close collaboration on these efforts ensured that the local public health departments had awareness of WellWise Services AAA's capabilities such as support for caregiver and Options Counseling. After working together and clarifying

eligibility requirements for services provided by WellWise Services, there was an increase in the number of referrals overall for these resources.

The partnership also includes discharge services and follow-up care. WellWise Services has funding through the Older Americans Act for pre- and post-discharge services. Before an individual is discharged, a WellWise Services representative creates a treatment plan while the older adult is in the hospital. After discharge, they use the treatment plan to make sure the older adult picks up their medication and understands their new diagnosis. WellWise Services worked closely with public health and health systems on the first iteration of this care transition project.

Communicating important public health information

The Safe Haven program, operated by WellWise Services, has produced formal resources, including a toolkit for public health and human service practitioners. Safe Haven serves older adults who have been victims of elder mistreatment. This program provides resources and wrap-around services, including temporary housing to older adults who have been abused, neglected, mistreated, or exploited. Safe Haven has received funding from the Michigan Health Endowment Fund to replicate the program across Michigan, since it is currently only offered in Hillsdale, Jackson, and Lenawee counties.

Guidance for Other States

For WellWise Services, knowing the location and service areas of local health departments will continue to be important. Meeting with key personnel from health departments will allow local health department staff to understand the value of AAAs and how the AAAs can help and support the health department. Project collaboration can solidify a partnership and provide an opportunity to support ongoing communication. Once the organizations are familiar with one other, they may be more likely to leverage the partnership when new issues arise.

The partnership between WellWise Services AAA and local public health departments illustrates the meaningful impact cross-sector collaboration can achieve. From improved emergency coordination to streamlined referrals and enhanced post-discharge support, the benefits for older adults are clear and measurable. These examples demonstrate how shared education, trust-building, and aligned priorities can strengthen community resilience. The Safe Haven model and its partnership strategies offer a promising blueprint for replication, reinforcing the critical role that integrated the public health and aging systems play in advancing the well-being of older adults.

Conclusion

The case studies highlighted in Wisconsin, Riverside County, and Michigan demonstrate that intentional collaboration between public health and aging services is both feasible and impactful. While each model reflects a different structure and approach, all underscore the value of aligning goals, leveraging complementary strengths, and building sustained partnerships to better serve older adults and caregivers. These efforts illustrate how breaking down silos can lead to more coordinated systems, streamlined service delivery, and improved access to care and supports. They also highlight how collaboration can strengthen the ability to address complex and interconnected needs, including those related to social determinants of health, ultimately advancing more equitable outcomes.

In addition, these examples show that there is no single model for success. Whether through structural integration, shared governance, coordinated referral systems, or community-based partnerships, progress is driven by a shared commitment to collaboration, communication, and continuous improvement. Strong leadership, data sharing, and a focus on community needs are key components that enable these partnerships to thrive and evolve over time.

Public health is uniquely positioned to play a central role in convening partners, advancing equity, and embedding

healthy aging into policies and programs. By strengthening partnerships with aging services, healthcare, and community-based organizations, public health can help align efforts across sectors and ensure that older adults are consistently prioritized. These coordinated approaches create more responsive, efficient, and person-centered systems that not only support older adults and their caregivers but also strengthen communities and promote health and well-being across the lifespan.

CROSS-STATE COMPARISON



	WISCONSIN	CALIFORNIA	MICHIGAN
Primary Strategy	Structural integration	Coordinated care	Local partnerships
Lead Organization	State government	County government	Area Agency on Aging
Largest Innovation	Shared governance	Single-entry system	Referral coordination
Key Lesson	Align agencies	Build integrated systems	Invest in partnerships

The infographic is titled "PUBLIC HEALTH" in a large, bold, black font at the top. Below the title, five public health strategies are listed, each with a corresponding icon in a circle and a brief description. The strategies are separated by horizontal lines. The strategies are: 1. Data Collection (bar chart icon), 2. Surveillance (magnifying glass icon), 3. Prevention (shield with cross icon), 4. Health Promotion (megaphone icon), and 5. Systems-Level Planning (gears icon).

PUBLIC HEALTH

- Data Collection**
Gather and analyze data to inform action
- Surveillance**
Monitor trends and identify emerging issues
- Prevention**
Prevent disease and adverse health outcomes
- Health Promotion**
Promote healthy behaviors and well-being
- Systems-Level Planning**
Design and coordinate effective policies and systems

AGING SECTOR

- Needs**
Deep understanding of older adults' needs
- Preferences**
Knowledge of preferences and priorities
- Lived Experiences**
Insight from lived experiences
- Community Voice**
Strong connection to older adults and caregivers in the community

Partnership & Collaboration

Jennifer Claar, Director of Integrated Health and Human Services, RivCo One

Nichole Baker, Aging & Adult Services Manager, Michigan's
Region 2 Area Agency on Aging

Kara Lorenz, Chief Operating Officer, WellWise Services
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