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An ad hoc committee of the National Academies of Sciences, Engineering, and Medicine examined the potential for integrating services addressing social needs and the social determinants of health into the delivery of health care to achieve better health outcomes and to address major challenges facing the U.S. health care system. These challenges, include persisting disparities in health outcomes among vulnerable subpopulations, often defined by a number of factors including age. Presenters will discuss and provide recommendations in the following areas: 1. evidence of impact of social needs care on patient and caregiver/family health and wellbeing, patient activation, health care utilization, cost savings, and patient and provider satisfaction; 2. opportunities and barriers to expanding historical roles and leadership of social workers in providing health-related social needs care and evidence-based care models that incorporate social workers and/or other social needs care providers in interprofessional care teams across the care continuum (e.g., acute, ambulatory, community-based, long-term care, hospice care, public health, care planning) and in delivery system reform efforts (e.g., enhancing prevention and functional status, care management, and transitional care; improving end-of-life care; integration of behavioral, mental, and physical health services); and 3. realized and potential contributions of social needs care to make health care delivery systems more community based, person- and family/caregiver-centered, and responsive to social and structural determinants of health, particularly for vulnerable populations and communities, such as older adults and low-income families. Examples for each of the three areas will also be presented.

DEPRESSION AND MEDICAL COST OF CARDIOVASCULAR DISEASES

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Prevalence of cardiovascular disease (CVD), the leading cause of death worldwide, increases with age. Depression is a prevalent comorbidity with CVD. This study investigates the medical costs of CVD associated with depression using a nationally representative data, 2015 Medical Expenditure Panel Survey. Patients aged ≥18 were identified by using the International Classification of Disease, 9th Revision codes of 390-459 for CVD and 296 or 311 for depression (N=23,755). Medical costs were actual payments received by providers and classified by service types and payment sources. We estimated the medical costs for each service type and payment source using economic modelling techniques controlling for various potential confounders. Overall prevalence of depression was 11.4%; 17.0% in persons with CVD and 8.7% in persons without CVD ($p<0.001$). Medical cost with depression was estimated at \$6900 ($p<0.001$) for persons with CVD and \$2211 ($p<0.001$) for those without. Costs on depression-related prescription medicines accounted for the largest portion of medical costs among persons with CVD (\$3095, $p<0.001$). For persons with depression but without CVD, costs on outpatient visits accounted for the largest proportion (\$1179, $p<0.001$). Medicare payments accounted for the largest portion of the depression-associated costs at \$3338 ($p=0.014$) for persons with CVD. Compared with persons without CVD, those with CVD demonstrated doubled rates of depression. Depression-associated medical costs among individuals with CVD were tripled what they were for persons without CVD. Increased costs associated with depression were mainly for prescribed medicines and were financed by Medicare programs for persons with CVD.

AGE AND USE OF COMPLEMENTARY AND ALTERNATIVE MEDICINE

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Complementary and alternative medicines (CAM) are often obtained over the counter and not disclosed to health care practitioners—leading to possible unforeseen, harmful drug interactions. These concerns are especially true for older adults who have a high likelihood of experiencing multiple comorbidities. Yet few studies examine the patterns of CAM use and disclosure across a wide age range. We used a mixed-methods in a study on patient attitudes toward CAM in a large primary care setting. Participants (n=279) ranged in age from 21-85 (mean=58), were mostly white (75%), and had a bachelor's degree or higher (83%). Most rated their physical health as good or very good (90%) and had a score of zero on the Charlson Comorbidity Index (76%). Use and disclosure of twelve types of CAM were assessed across three modalities including ingestible (e.g., herbs), psychological/mind-body (e.g., meditation), and physical (e.g., acupuncture). Age was not predictive of disclosure across the larger sample, but within respondents aged 65-85 (n=90), linear regression analyses showed likelihood of disclosure was associated with younger age, positive attitudes toward CAM, and expectation that their physician had positive attitudes about CAM. Semi-structured phone interviews (n=32) revealed older adults were more likely to have long-term CAM use, particularly for pain, and not feel it necessary to disclose to their physician. Meanwhile younger individuals reported trying CAM episodically for preventative health purposes. Understanding patterns of CAM use can help guide age-appropriate conversations and limit possible adverse outcomes from non-disclosure.

CUSTODIAL AND CO-RESIDENT GRANDMOTHERS SERVICE USE AND NEEDS: 10 YEARS APART

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The period between 2008 and 2017 spans a period of economic and societal flux in America, including the 2008 recession, the Affordable Care Act, and the emergence of the opioid crisis. These changes have had profound effects on families, including the rise in grandparent-headed and multigenerational households and their financial,