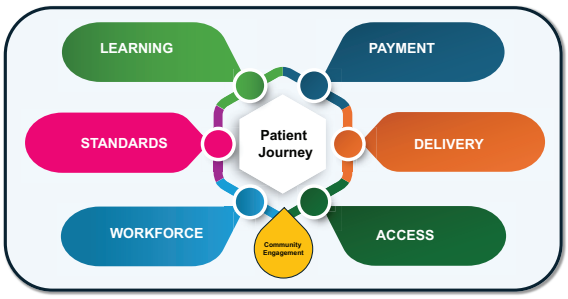
ROADMAP 2030

Impact Acceleration Strategy

Turning the roadmap into results

This Impact Acceleration Strategy translates Roadmap 2030 from solution design to scalable implementation—specifying catalytic priorities where coordinated, multi-stakeholder action drives system change. It reflects input from across the NEWDIGS collaborator community.

The framework providing the connective thread is the six Biomedical System Readiness (BSR) domains shown in the graphic. BSR is defined as the capability of health ecosystems to translate biomedical breakthroughs into timely, reliable, and equitable patient benefit at scale. These domains have emerged across nearly 20 years of NEWDIGS projects as critical dimensions of change within any disease ecosystem.



The six BSR domains—organizing framework for the Roadmap's target audiences

Achieving scalable, sustainable system change from Roadmap 2030 depends on execution of three objectives, each of which is supported by the BSR domains in different ways.

AWARENESS: Dissemination

Roadmap 2030's impact will be driven by the people and organizations across the Alzheimer's ecosystem who share and use it. The BSR domains organize the communities whose engagement is most critical to Roadmap impact. Materials available to support dissemination—including the Executive Summary, Issue Briefs, and shareable one-pagers—are posted at newdigs.tuftsmedicalcenter.org. Additionally, for each audience segment, purpose-driven dissemination strategies to support targeted outreach and activation have been developed can be found here.

ADOPTION: Implementation

Translating the Roadmap into practice through demonstration activity across the ecosystem—independently led by health systems, payers, clinical networks, and others – is critical. However, to achieve scale we must connect bottom-up clinical innovation to top-down policy change (see Figure 1, below). The six domains serve in this connector role by supporting policy change efforts through metrics resulting from a light-touch learning network: locally autonomous, linked through common metrics, so each site's experience contributes to shared learning and scalable system change.

ACHIEVEMENT: Measurement, learning, and system change

The Biomedical Health Efficiency (BHE) framework—a shared measurement model that will be used to enable learning, best practices, and scalable system change across participating demonstration sites is under active development, targeting delivery of an initial set of metrics by the end of 2026. Stakeholder input now, from all six BSR communities, is what makes it fit for purpose. BHE creates the measurement architecture, with each domain anchoring the evidence requirements of the decision-makers who operate within it. More information on BHE and our approach can be found here.

To discuss demonstration partnerships, BHE metric input, or customized dissemination materials, contact tuftsmcnewdigs@tuftsmedicine.org.

Our system change strategy

Several barriers that often prevent or slow the impact of even the best roadmaps:

- **Catalyzing implementation:** Roadmaps offer great thinking but are rarely implemented—key players in the system are not aware of the Roadmap or are unclear on what next steps might look like.
- **Coordinating across demonstrations:** Roadmaps that are implemented in fragmented ways, and/or where learning value is not captured may not generate optimal impact. Individual demonstration projects are challenged by a lack of time and resources, as well as legitimate concerns that agreeing to coordinate will slow them down (more meetings and bureaucracy) or undermine their autonomy to do what they know will work best in their local environment.

We believe: Innovation happens locally across highly distributed sites across the ecosystem. There are things that can be done centrally within a multi-stakeholder, pre-competitive environment like NEWDIGS that enable innovator organizations to contribute to scalable system change while also optimizing local success. Specifically, collaborative development of strategy and metrics can help all innovators to "pull in the same direction" using a "light touch" form of coordination to accelerate system change that cannot be achieved by one organization at a time.

- **Metrics that move systems:** Most of the time, organizational demonstration activities are evaluated by locally defined key performance indicators (KPIs) and can lead to valuable learnings for that organization. The lack of any standardized metrics—even simple ones—represents missed opportunities for cross-organizational learning, policy-aligned evidence generation, and scalable system change.

We believe: A common set of metrics 'designed backwards' from specific policy and system-change decisions, shaped with input from the decision-makers who would act on the evidence, and beginning with simple measures derived from secondary use of existing data—offers significant promise in accelerating actionable learning and scalable system

change. Such metrics span clinical outcomes, care quality, access, costs, and system readiness—whatever the targeted decision actually requires.

This framework—Biomedical Health Efficiency (BHE) is broader than quality measurement. It incorporates standardized quality metrics where they fit and extend beyond them by designing evidence packages prospectively from the decisions they need to move. Quality measures continue to do important work in the accountability and payment-policy infrastructure they have always served. BHE addresses what they do not reach.

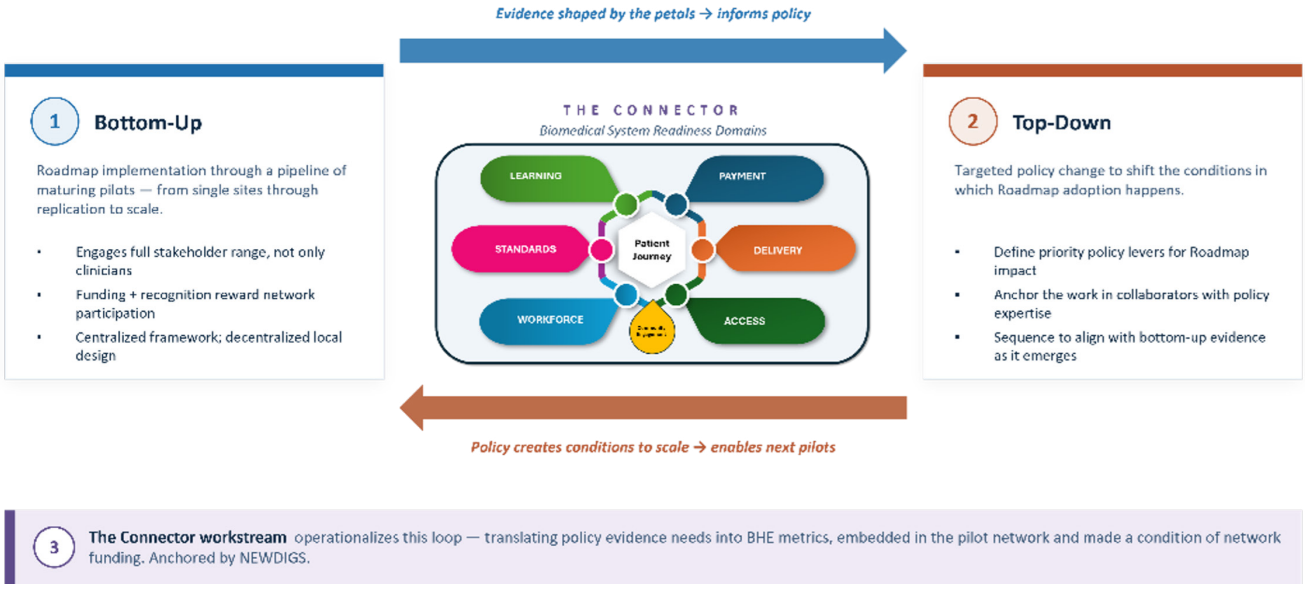
We are now developing BHE—to be tested first on early Alzheimer's disease.

Catalyzing high-impact implementation

Three workstreams, connected by the petals

The implementation model organizes activity into three mutually reinforcing workstreams. The graphic below captures the essential logic: bottom-up implementation and top-down policy change run in parallel, joined by a continuous-improvement loop. *The BSR domains—the petals—serve here as the connector: the shared framework that makes autonomous local activity legible to the broader ecosystem, and that ensures evidence generated at individual demonstration sites speaks to the decisions that matter across the full landscape of system change.*

Fig. 1: Three workstreams, connected by the petals—bottom-up implementation and top-down policy change, joined in a continuous-improvement loop by the Biomedical System Readiness Domains



1. Bottom-up: A pipeline of maturing demonstrations

Roadmap implementation begins with real-world demonstration activity—health systems, clinical networks, payer organizations, and others testing Roadmap recommendations in actual care settings. These demonstrations are not uniform: some are single-site pilots just getting started; others are mature programs ready to replicate or scale. The implementation model treats this diversity as a feature, not a problem—a pipeline of activity at different stages of development, each contributing to different kinds of evidence.

- **Engages the full stakeholder range**—not only clinicians, but payers, patient advocates, technology partners, and community organizations whose participation is required for sustainable system change.
- **Operates on a principle of centralized framework, decentralized local design:** shared strategy and metrics are defined pre-competitively; everything else is determined locally by people who understand their own systems.
- **Recognition within the NEWDIGS network** rewards participation and contribution to shared learning—creating a reputational incentive alongside the substantive value of cross-site evidence

2. Top-down: Targeted policy change

Demonstration activity alone is not sufficient for system change. Coverage decisions, reimbursement structures, clinical guidelines, and quality standards—the 'conditions' in which Roadmap adoption happens—are set by policy bodies whose processes are largely independent of what happens at individual demonstration sites. The top-down workstream is about changing those conditions deliberately and in sequence.

- **Priority policy levers** are identified across the six BSR readiness domains—the specific coverage decisions, guideline updates, and quality program changes that would most accelerate Roadmap adoption at scale.
- **Policy-expert collaborators** within the NEWDIGS community anchor this workstream—organizations with established relationships and credibility in the venues where these decisions are made.
- **Sequencing matters:** top-down policy advocacy is timed to align with the evidence emerging from bottom-up demonstrations, so that policy asks are supported by real-world proof rather than projections

3. The connector: BSR domains and BHE metrics

The third workstream is what makes the other two more than parallel tracks. The BSR readiness domains—the six 'petals'—define the landscape of system change that both workstreams are navigating. BHE metrics, organized across those domains, operationalize the loop: evidence generated by demonstration sites is shaped to answer the specific questions that policy decision-makers need answered. Policy changes, in turn, create the conditions—new reimbursement structures, updated guidelines, broadened coverage—that enable the next generation of demonstrations to go further.

- **Evidence shaped by the petals flows up:** BHE metrics translate local demonstration data into the form that coverage bodies, guideline panels, and quality programs can act on
- **Policy creates conditions to scale flows back**: each policy win reduces a barrier that was constraining demonstration activity, enabling sites to attempt what was previously impossible or unsustainable.
- **NEWDIGS anchors this workstream**—as the pre-competitive, multi-stakeholder body best positioned to define shared metrics, enable learning across diverse organizational types, synthesize cross-site evidence, and translate findings into policy-ready form

Accelerating scale and impact

The coordination problem—and the light-touch solution

Coordination has a bad reputation for healthcare innovation—and not without reason. The word conjures images of committee meetings, reporting requirements, and the slow erosion of the local autonomy that makes innovation possible in the first place. Organizations that are already stretched thin to run their own demonstration programs have little appetite for coordination overhead that consumes time without proportional return.

This is the wrong model of coordination, and it is not what this strategy proposes.

The light-touch coordination model is built on a simple premise: the most expensive and time-consuming parts of coordination—defining a shared strategy, developing common metrics, synthesizing cross-site evidence, translating findings for policy audiences—can be done *once, centrally, pre-competitively*, by NEWDIGS, for use by all sites with the network. Individual sites then inherit the benefits of that work without bearing its cost.

What this means in practice: a demonstration site that adopts BHE metrics does not need to design its own measurement framework, negotiate with payers about what evidence they need, or advocate individually for policy change. It contributes data to a shared infrastructure that does all of those things collectively—at a scale no single organization could achieve alone.

What NEWDIGS does centrally	What demonstration sites retain locally
Defines shared strategy and priority policy levers across the BSR domains	Full autonomy over local implementation design, clinical protocols, and care model decisions
Develops and maintains the BHE metric set with input from all stakeholder communities	Choice of which additional local metrics to track beyond the shared core set
Synthesizes cross-site evidence into policy-relevant form	Control over pace and timing of all activities
Provides a reusable playbook that reduces startup costs for new sites	Credit for their own contributions to the evidence base
Feedback to implementation sites, and communication of shared findings to NEWDIGS community and the public	Control over how findings are communicated locally and to their own stakeholders

A better return on existing investment

Across the Alzheimer's ecosystem, substantial resources have been invested in demonstrations and pilot activity over the past several years. The results at the local level have often

been encouraging—teams have learned what works in their environment, care pathways have improved, and individual sites have made genuine progress. Yet system-level change has remained elusive. Coverage decisions have not shifted. Clinical guidelines have not been updated at the pace the science warrants. The gap between what individual demonstrations prove and what the broader system adopts remains wide.

The explanation is not that the demonstrations were poorly designed, or the evidence was weak. It is that evidence generated locally, measured against locally defined metrics, and communicated in locally specific terms cannot aggregate into the kind of signal that moves system-level decision-makers. A payer considering a coverage change needs to see consistent findings across diverse settings. A guideline panel needs evidence that a care pathway works across different patient populations. A quality program needs a metric that is computable from existing data at hundreds of sites simultaneously. Local demonstrations, however rigorous, rarely produce evidence in this form—not because they couldn't, but because no one asked them to or enabled this from the start.

BHE participation changes this. When demonstration sites adopt shared cascade metrics from the outset—metrics designed explicitly to answer the questions that payers, guideline panels, and quality programs ask—their individual results become contributions to a collective evidence base. The same investment in local demonstration activity produces both local learning and system-level evidence. Funders who require BHE participation as a condition of the demonstration activities they support are not adding a burden—they are ensuring their investment generates its full potential return.

The win-win-win

Demonstration sites get shared infrastructure, cross-site learning, and policy impact they could not achieve alone—without giving up local design autonomy.

Funders get a return that extends beyond any single demonstration—their investment contributing to the policy-level evidence base that makes system change possible.

The field gets a compounding evidence base that accelerates coverage decisions, guideline updates, and quality program changes that no individual demonstration could drive alone.

Where things stand—and what comes next

The next phase of work, running through end of 2026, focuses on three things in parallel:

Formalizing network structure: developing the guiding principles, simple statements of intent to participate and summary reporting formats needed to facilitate cross-site learning while protecting site autonomy and data privacy.

Finalizing BHE metrics: completing the co-design and initial validation process for the early AD metric set with input from potential demonstration sites, payers, patient advocates, industry, and policy partners so that sites joining the network in 2027 have a field-ready measurement framework from day one.

Engaging the first cohort of sites: moving from exploratory conversations to formal participation commitments with the initial group of demonstration sites.

The network does not need to be large to be powerful. A small number of sites, diverse in their settings, patient populations, and organizational types, generating evidence against a shared metric framework is more valuable to the field than a large number of sites each measuring something different. The goal in 2026 is not scale. It is proof that the model works, that light-touch coordination can turn distributed innovation into collective impact.

About NEWDIGS and Roadmap 2030

The NEWDIGS Consortium is the flagship program of the Tufts Center for Biomedical System Design at Tufts Medical Center. All Roadmap 2030 and Biomedical System Readiness materials are open access at newdigs.tuftsmedicalcenter.org.