GERONTOLOGICAL SOCIETY OF AMERICA®

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Meaningful Lives As We Age

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Agency for Healthcare Research and Quality
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On behalf of the Gerontological Society of America (GSA), we appreciate the opportunity to provide the Agency for Healthcare Research and Quality (AHRQ) information about the impact of ageism in healthcare and methods and strategies to address ageism in healthcare delivery.

GSA's mission is to foster excellence, innovation, and collaboration to advance aging research, education, practice, and policy, and our vision is "meaningful lives as we age." GSA's 6,000 members include gerontologists, health professionals, behavioral & social scientists, biologists, demographers, economists, and many other disciplines. These experts study all facets of aging with a life-course orientation. The multidisciplinary nature of the GSA membership is a valued strength, enabling the Society to provide a 360-degree perspective on the issues facing our population as we age.

GSA serves as the home of the National Center to Reframe Aging, which is dedicated to ending ageism by advancing an equitable and complete story about aging in America. The center is the trusted source for proven communication strategies and tools to effectively frame aging issues. It is the nation's leading organization, cultivating an active community of individuals and organizations to spread awareness of implicit bias toward older people and influence policies and programs that benefit all of us as we age. Led by the GSA, the National Center acts on behalf of and amplifies the efforts of the ten Leaders of Aging Organizations.

By promoting a greater understanding of aging and implicit bias, the National Center is advancing a more equitable and complete story about aging in America. The National Center offers proven communication strategies and tools help organizations and individuals effectively frame issues around aging and confront the injustice of ageism. It also is building a community of local organizations, working together to ensure supportive policies and programs for all of us as we age.

1. What is the scope of ageism in health care and its impacts? Can you provide specific examples, especially those that are wide-spread and/or have large impact?

The term ageism was coined in 1968 by Robert Butler—a Pulitzer Prize winning gerontologist and GSA Fellow and award winner. He served as the founding director of National Institute on Aging (NIA), and gave age-based discrimination/ageism a name, and defined it as "systematic stereotyping and discrimination against people simply because they are old.[1]" The World Health Organization (WHO) states that "ageism refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age."

According to a research article titled "Carta of Florence Against Ageism: No Place for Ageism in Healthcare," all aspects of healthcare, from education to acute and long-term care, along with population-level prevention, remain outdated and inadequate to meet the expanding needs of the aging population, and ageism in healthcare is unlikely to be solved until endemic ageism is addressed[2].

[1] Butler, R. N. (2008). The longevity revolution: The benefits and challenges of living a long life. PublicAffairs.
[2] Andrea Ungar, Antonio Cherubini, Laura Fratiglioni, Vânia de la Fuente-Núñez, Linda P Fried, Marlane Sally Krasovitsky, Mary E Tinetti, Alana Officer, Bruno Vellas, Luigi Ferrucci, Carta of Florence Against Ageism: No Place for Ageism in Healthcare, *The Journals of Gerontology: Series A*, Volume 79, Issue 3, March 2024, glad264, https://doi.org/10.1093/gerona/glad264

According to the article, for many years, the medical approach to health focused on the diagnosis, management, and cure of single diseases[3]. "At a time when the proportion of older people in the population was low and longevity was rare, middle-aged individuals with single, usually acute, diseases accounted for most of the patients seeking care. The common, general paradigm was to treat each disease at the time of clinical emergence, prescribing therapy and sending patients home to heal or die. The mantra 'one patient—one problem' has survived for hundreds of years. This approach ignored patients with multiple conditions, frailty, and disability, considering these problems 'normal consequences of ageing,' 'too complex' and 'unlikely to respond to care.[4]"

Until the last few decades, this approach did not substantially change despite emerging evidence that prevention of diseases, health promotion, and productive employment matter into the oldest ages. "With the aging of the population and a substantial reduction of mortality at older ages, there has been a switch in the profile of patients accessing clinical services. Patients are now mostly affected by multiple chronic medical conditions that adversely impact their physical and cognitive function. To date, healthcare systems have only partially responded to such extensive transformation of population health, and the introduction of geriatrics as a medical specialty in health care is still rare.[5]"

Researchers note that the overarching mission of medical care remains rooted in the cure of a single disease, a strategy that conflicts with the already large and growing older population characterized by new patterns of morbidity and expanded health outcomes. "Ageism is a substantial obstacle to both valuing and investing in health and social care that matches the new needs and opportunities for the health of our aging population.[6]"

For example, older people also experience discrimination in their access to preventive measures, such as mammography screening[7]. According to research, "older patients, based on their chronological age, are less likely to be eligible to receive intensive care or complex medical and surgical treatment, regardless of the severity of their baseline condition, or their level of intrinsic capacity."

The findings from a series of studies suggest that ageism may be associated with short- and long-term physiological health consequences[8]. Researchers documented "heightened cardiovascular stress responses (i.e., increased blood pressure, heart rate, and skin conductance) among older adults subliminally exposed to negative ageing stereotypes compared with those exposed to positive stereotypes. Frequent elevation of blood pressure and heart rate can lead to hypertension and may contribute to or exacerbate other chronic health issues such as heart disease, stroke, kidney disease, obesity, and diabetes."

2. How does ageism influence healthcare access, quality, safety, and outcomes of care?

The universal undervaluing of older people permeates our culture and is at the root of ageism in healthcare[9]. Ageism can also be internalized and eventually applied to oneself (self-directed ageism)[10]. In particular, older people may internalize the stereotype that older age is a period of inevitable disease and decline, a thought process that can impose barriers to engaging in health-promoting behaviors and accessing health and social care at an older age[11].

Persistent stigma, ageism, and stereotypes endemic to healthcare, and society at large, contribute to the devaluing of geriatrics content, reducing the potential for effective and equitable care for older adults[12]. Research suggests that geriatric educators are challenged to address the ingrained stigma and ageism among both their learners and healthcare organizations. "However, re-

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[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Julie Ober Allen, Ageism as a Risk Factor for Chronic Disease, *The Gerontologist*, Volume 56, Issue 4, August 2016, Pages 610–614, https://doi.org/10.1093/geront/gnu158
[9] Andrea Ungar, Antonio Cherubini, Laura Fratiglioni, Vânia de la Fuente-Núñez, Linda P Fried, Marlane Sally Krasovitsky, Mary E Tinetti, Alana Officer, Bruno Vellas, Luigi Ferrucci, Carta of Florence Against Ageism: No Place for Ageism in Healthcare, *The Journals of Gerontology: Series A*, Volume 79, Issue 3, March 2024, glad264, https://doi.org/10.1093/gerona/glad264
[10] Ibid.
[11] Ibid.
[12] John Schumacher, Laura Finn, STIGMA AND AGEISM IN THE GERIATRIC EDUCATION CONTEXT: USING PATIENT-CENTERED CARE APPROACHES, *Innovation in Aging*, Volume 8, Issue Supplement_1, December 2024, Page 332, https://doi.org/10.1093/geroni/igae098.1083

imagining geriatrics education to be anchored in a patient-centered care approach, addressing specific, concrete patient needs, has been shown to reduce ageist attitudes and behaviors in the healthcare workforce. Participating in intergenerational activities has also shown a positive impact on health care provider attitudes toward older patients.[13]"

Investment in healthcare is mostly directed to disease treatment, that is, care of diseases when they become clinically evident, rather than on prevention or health promotion over the life course[14]. Progress in medical care has therefore mostly extended the length of life characterized by disease, with little effect on health expectancy and healthy longevity[15].

Research shows that older patients, based on their chronological age, are less likely to be eligible to receive intensive care or complex medical and surgical treatment, regardless of the severity of their baseline condition, or their level of intrinsic capacity[16].

According to "Carta of Florence Against Ageism: No Place for Ageism in Healthcare," validation of the efficacy and safety of treatments often does not apply to older patients, especially those with clinical and social complexity[17]. "Additionally, tools that can be used on a large scale for risk stratification are lacking, preventing older people from the possibility of receiving proper prognostic assessment and getting access to specific care and clinical pathways. Validation of the efficacy and safety of treatments often does not apply to older patients, especially those with clinical and social complexity. Additionally, tools that can be used on a large scale for risk stratification are lacking, preventing older people from the possibility of receiving proper prognostic assessment and getting access to specific care and clinical pathways."

3. What is the impact of ageism on both the micro and macro levels of health care? How does this vary across diverse population groups, including older adults living in rural or socioeconomically disadvantaged areas, those with low incomes or from racial or ethnic minority groups, or those living with disabilities? Between women and men?

In research published in "Age Equity: A Framework for Addressing Ageism, Stigma, and Bias," experiences of ageism were associated with higher rates of stigma, lifetime victimization, discrimination, lower support and community engagement, and adverse outcomes (lower mental and physical health and quality of life)[18]. The rapidly growing older adult population highlights the pressing need to consider age inequities and the importance of achieving age equity across the life course. These findings were the result of utilizing an Age Equity Framework to investigate ageism based on research findings from the 2018 National Health, Aging and Sexuality/Gender Study (NHAS): Aging with Pride[19].

Within healthcare settings, several studies have documented interpersonal stigmatization and prejudice toward older people experiencing homelessness[20]. Researchers have found that when attempting to access medical care, older people experiencing homelessness felt stigmatized by healthcare providers, including physicians, with participants noting that some general practitioners do not provide care to patients with complex health or comorbid mental and physical conditions. Another study of people aged 50 years and older who had experienced chronic homelessness found that participants experienced significant barriers to healthcare linked to long wait lists, prohibitive costs, and asking for but not receiving help[21]. Based on these findings, researchers suggest that future studies should consider the role of age-based prejudice in instances of service or care denial[22].

The findings published in a research article titled "A Phenomenological Understanding of the Intersectionality of Ageism and Racism Among Older Adults: Individual-Level Experiences" indicates that anti-racist and anti-ageist educational initiatives should

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[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Andrea Ungar, Antonio Cherubini, Laura Fratiglioni, Vânia de la Fuente-Núñez, Linda P Fried, Marlane Sally Krasovitsky, Mary E Tinetti, Alana Officer, Bruno Vellas, Luigi Ferrucci, Carta of Florence Against Ageism: No Place for Ageism in Healthcare, *The Journals of Gerontology: Series A*, Volume 79, Issue 3, March 2024, glad264, https://doi.org/10.1093/gerona/glad264
[17] Ibid.
[18] Karen Fredriksen Goldsen, Charles Emlet, Age Equity: A Framework for Addressing Ageism, Stigma, and Bias, *Innovation in Aging*, Volume 5, Issue Supplement_1, 2021, Page 429, https://doi.org/10.1093/geroni/igab046.1667
[19] Ibid.
[20] Canham, S. L., Battersby, L., Fang, M. L., Wada, M., Barnes, R., & Sixsmith, A. (2018). Senior services that support Housing First in Metro Vancouver. Journal of Gerontological Social Work, 61(1), 104–125. doi:10.1080/01634372.2017.1391919
[21] Milaney, K., Kamran, H., & Williams, N. (2020). A portrait of late life homelessness in Calgary, Alberta. Canadian Journal on Aging, 39(1), 42–51. doi:10.1017/S0714980819000229
[22] Ibid.

collaborate and be applied across the life course within health care settings to help prevent the negative impacts of racialized ageism[23]. Future research should explore the intersectional impacts of ageism and racism on specific health outcomes in addition to structural-level interventions[24].

Research shows that older people living with a disability are negatively stereotyped and face poor healthcare treatment (e.g., lack of follow-up and delayed treatments).[25]A systematic review of 10 databases and 354 ageism studies from 2019 to 2022 which examined the intersections of ageism with other "isms" during the COVID-19 pandemic found evidence of older adults living with a disability facing serious stigma in healthcare triage decisions which were based on evaluations of older age and frailty[26].

According to research, sexual minority older people age at the same rate as their heterosexual counterparts and experience similar, if not greater, challenges accessing health care[27]. Yet, sexual minority older adults also have unique needs and experiences related to their identities that are often overlooked in both scientific and clinical settings[28]. In addition, a recent study highlights potential directions for behavioral health care, including promoting sexual minority older peoples' use of social support given its strong association with better psychological well-being[29].

4. What is the evidence for interventions to address ageism and promote age inclusivity in healthcare?

Ageism might result in mis- or overtreatment, that is, provision of a treatment intervention that is based on disease-specific evidence generated in younger adults and extrapolated to older people[30]. Research suggests that in addition to acquiring and using therapeutic evidence on functional, symptom-based, and quality of life outcomes in older adults with multiple conditions, care should focus on identifying the specific health outcome goals of older adults and implementing realistic care aligned with meeting these goals[31]. Treatment should be decided in collaboration with the patient and in the context of their comorbidity, functional capacity, social support, and living environment[32].

Older patients should be included in clinical trials aimed to test interventions that may become beneficial to them. Policies should be generated to promote and ensure adequate representation of older people in research. Data should be more extensively stratified by age and health status measures and require functional, symptom, and quality of life outcomes in addition to disease-specific outcomes and survival[33]. There is a need for integrated and coordinated health and social care networks to promote more comprehensive and effective assistance. Geriatric medicine may play a pivotal role in the oversight of this process, favoring connections and integration between specialized settings (e.g., by designing, overseeing, and coordinating a care plan from acute care, to sub-intensive care, to rehabilitation, and then to long-term care solutions) and primary care services[34].

"Identifying the health outcome goals of each individual using a person-centered care approach and providing a comprehensive explanation of the consequence(s) of alternative therapeutic choices to allow shared decision making should become an integral

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[23] Andrew T Steward, Carson M De Fries, Annie Zean Dunbar, Miguel Trujillo, Yating Zhu, Nicole Nicotera, Leslie Hasche, A Phenomenological Understanding of the Intersection-ality of Ageism and Racism Among Older Adults: Individual-Level Experiences, The Journals of Gerontology: Series B, Volume 78, Issue 5, May 2023, Pages 880–890, https://doi.org/10.1093/geronb/gbad031
[24] Ibid.
[25] Levy, S. R., Lytle, A., & Macdonald, J. L. (2022). The worldwide ageism crisis. Journal of Social Issues, 78(4), 743–768. https://doi.org/10.1111/josi.12568
[26] Ramírez, L., Monahan, C., Palacios-Espinosa, X., & Levy, S. R. (2022). Intersections of ageism toward older adults and other isms during the COVID-19 pandemic. Journal of Social Issues, 78(4), 965–990. https://doi.org/10.1111/josi.12574
[27] Molinari, C. A., & McSweeney-Feld, M. H. (2017). At the intersection of ageism and heterosexism: Making the case to deliver culturally competent health care for LGTB older adults. The Journal of Health Administration Education, 34(3), 473–488.
[28] Ibid.
[29] Bethany P Detwiler, Grace I L Caskie, Nicole L Johnson, It's Complicated: Minority Stress, Social Support, In-Group Social Contact, and Sexual Minority Older Adults' Well-Being, *The Gerontologist*, Volume 63, Issue 2, March 2023, Pages 350–360, https://doi.org/10.1093/geront/gnac092
[30] Andrea Ungar, Antonio Cherubini, Laura Fratiglioni, Vânia de la Fuente-Núñez, Linda P Fried, Marlane Sally Krasovitsky, Mary Tinetti, Alana Officer, Bruno Vellas, Luigi Ferrucci, Carta of Florence Against Ageism; No Place for Ageism in Healthcare, *Innovation in Aging*, Volume 8, Issue 2, 2024, igad133, https://doi.org/10.1093/geroni/igad133
[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] Ibid.

component of medical education and practice. This is particularly important for older patients who are often affected by complex health problems not amenable to a 'cure'.[35]" Research shows that patient-reported outcomes and experiences (person-reported outcome measure and patient-reported experience measures) should receive proper attention in medical and paramedical education. Caregivers should be involved in clinical decision making, as appropriate, taking into consideration the preferences and priorities of those they care for[36].

5. How do age-related stereotypes affect clinical decision-making, and what steps can be taken to ensure that care plans align with older adults' individual needs, preferences, and goals?

Research in "How Stereotype Threat Affects Healthy Older Adults' Performance on Clinical Assessments of Cognitive Decline: The Key Role of Regulatory Fit" offers insight into why stereotype threat affects older people and how this can affect clinically-relevant outcomes[37]. "Results suggest that older adults respond to stereotype threat by becoming vigilant to avoid confirming the conclusion that they have experienced cognitive declines. However, researchers and clinicians can capitalize on this motivational change to combat stereotype threat's negative effects. By using a loss-avoidance frame to the task, stereotype threat effects can be ameliorated or even eliminated.[38]"

Research indicates that clinical decision-making does not adequately consider alternatives of care that may better align with subjective priorities and preferences of older patients, including the decision to withhold treatment to avoid iatrogenic harm[39]. "For example, function, frailty, and disability are often appropriate primary targets of interventions, but older people may not be involved in the development of a care plan with these goals in mind[40]."

Ageism and stereotyping in healthcare has "implicated in the over- or under-diagnosis and/or treatments provided to older persons, resulting in decreased quality of life and increased costs of care.[41]" Responses from a study titled, "Challenging Ageism in Healthcare Through Interprofessional Education" illustrate the need to and value of incorporating anti-ageism content into educational programs of our future health and social care workforce[42].

An effective strategy to advance person-centered care is to utilize the Age-Friendly Health Systems framework, using the 4Ms as a framework to improve care for older adults: what Matters, Medication, Mentation and Mobility[43]. In "What Matters," person-centered care is effective in strengthening care plans for older people. This includes knowing and aligning care with each older person's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.[44]

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[35] Ibid.
[36] Ibid.
[37] Sarah J. Barber, Mara Mather, Margaret Gatz, How Stereotype Threat Affects Healthy Older Adults' Performance on Clinical Assessments of Cognitive Decline: The Key Role of Regulatory Fit, *The Journals of Gerontology: Series B*, Volume 70, Issue 6, November 2015, Pages 891–900, https://doi.org/10.1093/geronb/gbv009
[38] Ibid.
[39] Andrea Ungar, Antonio Cherubini, Laura Fratiglioni, Vânia de la Fuente-Núñez, Linda P Fried, Marlane Sally Krasovitsky, Mary E Tinetti, Alana Officer, Bruno Vellas, Luigi Ferrucci, Carta of Florence Against Ageism: No Place for Ageism in Healthcare, *The Journals of Gerontology: Series A*, Volume 79, Issue 3, March 2024, glad264, https://doi.org/10.1093/gerona/glad264
[40] Ibid.
[41] Min Kyoung Park, Diane Martin, CHALLENGING AGEISM IN HEALTHCARE THROUGH INTERPROFESSIONAL EDUCATION, *Innovation in Aging*, Volume 6, Issue Supplement_1, November 2022, Page 762, https://doi.org/10.1093/geroni/igac059.2764
[42] Ibid.
[43] Laurence Solberg, Shivani Jindal, Kimberly Church, Andrea Schwartz, IMPLEMENTING AGE-FRIENDLY HEALTH SYSTEMS: SCALING 4MS CARE ACROSS VA, *Innovation in Aging*, Volume 7, Issue Supplement_1, December 2023, Page 929, https://doi.org/10.1093/geroni/igad104.2985
[44] *Age-Friendly Health Systems Initiative*. (n.d.). The John A. Hartford Foundation. https://www.johnahartford.org/grants-strategy/current-strategies/age-friendly/age-friendly-health-systems-initiative

6. How does internalized and interpersonal ageism impact care seeking behavior and health outcomes? What strategies are there to address this?

Internalized ageism is associated with numerous public health outcomes, including physical and mental health, functional impairment, cognition, cardiovascular stress, hospitalizations, and longevity[45]. "Older adults who internalize ageism experience worsening of physical and cognitive health and a shorter life expectancy than older adults with positive aging beliefs. People with negative aging stereotypes may disengage from healthy behaviors, such as taking prescribed medication, participating in physical activities, or following a healthy diet, because they will not see the potential gain from such behavior. Older people may also refuse to access health and social care services, because they believe that they do not deserve equal access and social care service or there is an associated stigma.[46]"

Research further suggests that positive age beliefs, which are modifiable and have been found to reduce stress, can act as a protective factor, even for older individuals at high risk of dementia[47].

In a study that used "Reimagine Aging," a six-week process-based intervention to reduce internalized ageism tools of education, acceptance and commitment therapy, and attributional retraining, results demonstrated that participants' self-perceptions of aging became significantly more positive and maintained these gains at follow-up, associated with large effect sizes[48].

Interventions that support positive aging beliefs are available that have been shown to improve aging perceptions and health, and these interventions should be broadly disseminated and supported[49]. Research findings suggest that interventions with older people must include consciousness-raising about ageism and its consequences well as common examples and skills to combat it[50].

7. How can healthcare technology, such as electronic health records and decision-support tools, as well as artificial intelligence be designed to mitigate ageism rather than reinforce it?

Transforming primary care practice to improve the health of older adults is a major focus of the Geriatric Workforce Enhancement Program (GWEP)[51]. Using the 4Ms of an Age-Friendly Health System (What Matters, Mentation, Medication, and Mobility) as a framework in primary care practices also applies to using electronic health records and other health technologies.

University of California–Irvine (UCI) GWEP's "Technology-Advanced Geriatrics: Together, Educating, Advocating, and Mentoring (TAG-TEAM)," serves an area in California where health disparities follow zip codes. Partnering with Federally Qualified Health Centers (FQHC), the team succeeded in helping partner clinics gain Age-Friendly Health Systems designation via in-person training as well as virtual education using an Age-Friendly Geriatrics Tele-ECHO program[52]. "A newly created Annual Wellness Visit template ensures the 4Ms and social determinants of health are addressed. The UCI GWEP also pioneered a Digital Health Literacy

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[45] Andrew Steward, Toward interventions to reduce internalized ageism, *Innovation in Aging*, Volume 5, Issue Supplement_1, 2021, Page 598, https://doi.org/10.1093/geroni/igab046.2296

[46] Ibid.

[47] Levy BR, Slade MD, Pietrzak RH, Ferrucci L (2018) Positive age beliefs protect against dementia even among elders with high-risk gene. PLoS ONE 13(2): e0191004. https://doi.org/10.1371/journal.pone.0191004

[48] Dallas Murphy, Michelle Porter, Corey Mackenzie, Judith Chipperfield, THE EFFECTIVENESS OF REIMAGINE AGING: AN INTERVENTION TO REDUCE INTERNALIZED AGEISM IN OLDER ADULTS, Innovation in Aging, Volume 7, Issue Supplement_1, December 2023, Pages 1172–1173, https://doi.org/10.1093/geroni/igad104.3759

[49] Andrea Ungar, Antonio Cherubini, Laura Fratiglioni, Vânia de la Fuente-Núñez, Linda P Fried, Marlane Sally Krasovitsky, Mary Tinetti, Alana Officer, Bruno Vellas, Luigi Ferrucci, Carta of Florence Against Ageism; No Place for Ageism in Health Care, *The Gerontologist*, Volume 64, Issue 4, April 2024, gnae001, https://doi.org/10.1093/geront/gnae001

[50] Aaron Li, Nancy Morrow-Howell, Natalie Galucia, Khrystal Johnson, Brian Carpenter, UNDERSTANDING AND EXPERIENCING AGEISM: PERSPECTIVES FROM OLDER ADULTS, *Innovation in Aging*, Volume 8, Issue Supplement_1, December 2024, Page 1223, https://doi.org/10.1093/geroni/igae098.3915

[51] Marla Berg-Weger, Erin Emery-Tiburcio, Nina Tumosa, Transforming Primary Care Practice Into Age-Friendly Health Systems, *Innovation in Aging*, Volume 4, Issue Supplement_1, 2020, Page 729, https://doi.org/10.1093/geroni/igaa057.2588

[52] Barbara A Gordon, Lilian Azer, Katherine Bennett, Linda S Edelman, Monica Long, Anna Goroncy, Charles Alexander, Jung-Ah Lee, Rosellen Rosich, Jennifer J Severance, Agents of Change: Geriatrics Workforce Programs Addressing Systemic Racism and Health Equity, *The Gerontologist*, Volume 64, Issue 6, June 2024, gnae038, https://doi.org/10.1093/geront/gnae038

Assessment Tool and Center to address the digital divide facing our older adult populations. These GWEP programs have resulted in organizational change, including improved quality metrics.[53]"

Researchers say artificial intelligence (AI) enhances the roles of healthcare professionals and scientists, offering tools and insights that were previously unimaginable. It brings a level of precision, efficiency, and predictive power to healthcare, changing how we approach diagnosis, treatment, and patient care[54]. According to research published in "Artificial Intelligence in Geriatrics: Riding the Inevitable Tide of Promise, Challenges, and Considerations" AI in healthcare faces challenges, including algorithmic biases and data quality issues. Studies have shown that AI tools can unintentionally perpetuate racial and gender biases present in healthcare data. Addressing these biases is crucial for the equitable application of AI in healthcare. The integration of AI for older adults is also not without challenges. Existing systems often reflect societal biases, particularly ageism, neglecting the needs and preferences of older adults. This issue is evident in the way older adults interact with technologies like voice assistants. In addition, and specifically in the older adult's domain, there is a narrow focus on accessibility, often conflating aging with disability, which inadvertently excludes older adults from the wider benefits of technology."

8. What role could Medicare, Medicaid, and private insurers play in incentivizing equitable, high-quality care for older adults and combating systemic ageism?

Medicare and Medicaid could encourage healthcare providers to adopt Age-Friendly Health Systems as a framework in primary care and other clinical practices. Led by the Institute of Healthcare Improvement, in partnership with the American Hospital Association and the Catholic Health Association, the Age-Friendly Health Systems movement is rapidly growing, with participation in all 50 states from over 450 sites, including the full continuum of care settings[55]. Partnerships with private and public entities are accelerating the work. As one example highlighted earlier, the Health Resources and Services Administration has embedded Age-Friendly Health Systems principles into the GWEPs[56]. These programs have advanced Age-Friendly Health Systems principles in federally-funded community health centers.

Reimbursement rates in Medicare and Medicaid are not keeping up with healthcare costs, leading private providers to not treat beneficiaries, leading to lower health outcomes in older people especially those with barriers to social determinants of health. According to research, reimbursement by Medicare for emergency physician services "decreased by an average of 29.13% from 2000 to 2020 after adjusting for inflation. There was a stable decline in adjusted reimbursement rates throughout the study period, with an average decrease of 1.61% each year. The largest decrease was seen for laceration repairs up to 7.5 cm, with reimbursement rates for all 4 relevant Current Procedure Terminology codes decreasing by more than 60%[57]."

9. What are the broader societal benefits of reducing ageism in healthcare, such as enhanced workforce participation of older adults, lower healthcare costs, and improved intergenerational health?

The United Nations (UN) Decade of Healthy Ageing (2021–2030) has identified ageism as a global obstacle that curtails older persons' opportunities to contribute to society, realize their full potential, and lead a fulfilling life[58]. The U.S. National Academy of Medicine's Global Roadmap for Healthy Longevity reinforced the need to address ageism and identified training, education, and

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[53] Ibid.

[54] Peter Abadir, Rama Chellappa, Artificial Intelligence in Geriatrics: Riding the Inevitable Tide of Promise, Challenges, and Considerations, *The Journals of Gerontology: Series A*, Volume 79, Issue 2, February 2024, glad279, https://doi.org/10.1093/gerona/glad279

[55] Terry Fulmer, Creating Age-Friendly Health Systems: Age Matters, *Innovation in Aging*, Volume 4, Issue Supplement_1, 2020, Page 865, https://doi.org/10.1093/geroni/igaa057.3193

[56] Ibid.

[57] Jordan R. Pollock, Tanner R. Bollig, Jack M. Haglin, Benjamin J. Sandefur, Douglas E. Rappaport, Rachel A. Lindor, Medicare Reimbursement to Physicians Decreased for Common Emergency Medicine Services From 2000 to 2020, Annals of Emergency Medicine, Volume 76, Issue 5, 2020, Pages 615-620, ISSN 0196-0644, https://doi.org/10.1016/j.annemergmed.2020.06.017. https://www.sciencedirect.com/science/article/pii/S019606442030456X

[58] Andrea Ungar, Antonio Cherubini, Laura Fratiglioni, Vânia de la Fuente-Núñez, Linda P Fried, Marlane Sally Krasovitsky, Mary E Tinetti, Alana Officer, Bruno Vellas, Luigi Ferrucci, Carta of Florence Against Ageism: No Place for Ageism in Healthcare, *The Journals of Gerontology: Series A*, Volume 79, Issue 3, March 2024, glad264, https://doi.org/10.1093/gerona/glad264

new social infrastructure that values and enables the contribution of older adults as critical steps to promoting healthy longevity as one of the core missions of healthcare systems and society as a whole[59].

Pervasive ageism in healthcare negatively affects healthy survival and trajectories of health and well-being of older persons and curtails individuals' capacity to contribute to societal goals. Thus, tackling ageism in healthcare would benefit the society at large[60].

Eliminating ageism would lower healthcare costs. "Ageism Amplifies Cost and Prevalence of Health Conditions" is the first study to identify the economic cost that ageism imposes on health. The findings suggest that a reduction of ageism would not only have a monetary benefit for society but also have a health benefit for older people. The study found that the one-year cost of ageism was $63 billion, or one of every seven dollars spent on the eight health conditions (15.4%), after adjusting for age and sex as well as removing overlapping costs from the three predictors. According to the model used, ageism resulted in 17.04 million cases of these 8 health conditions.

Studies have shown that ageism diminishes students' interest in pursuing education and careers in aging-related fields, leading to shortages in the gerontology and geriatrics workforce. Education, combined with service-learning experiences, provides an opportunity for intergenerational interaction, leading to a reduction in ageism[61].

Findings presented in "Reducing Ageism With Brief Videos About Aging Education, Ageism, and Intergenerational Contact" highlight the promise of providing information about aging and positive intergenerational contact to reduce ageism[62]. Research shows that brief online educational videos based on the Positive Education about Aging and Contact Experiences model hold promise as an effective tool to reach a wide audience and reduce ageism[63].

10. What are the unique challenges and opportunities for addressing ageism in healthcare in an aging population and increasing healthcare demand?

There is a lack of communication and connection between the different settings and the health and social care professionals that provide care for the same person, especially for older people with cognitive impairment who cannot advocate for themselves[64]. Research shows opportunity "for integrated and coordinated health and social care networks to promote more comprehensive and effective assistance. Geriatric medicine may play a pivotal role in the oversight of this process, favoring connections and integration between specialized settings (eg, by designing, overseeing, and coordinating a care plan from acute care, to sub-intensive care, to rehabilitation, and then to long-term care solutions) and primary care services.[65]"

According to research published on ageism in "Carta of Florence Against Ageism; No Place for Ageism in Healthcare," the demographic imperative of longevity and aging has led to an unprecedented expansion of the older population that is affected by chronic conditions and disabilities, making older people major healthcare users[66]. "This gradual transition now requires a profound and global transformation of the organization of healthcare for the individual as well as population-focused approaches to achieve healthy longevity. This will require the education of the healthcare and public health workforce and demands a stronger involvement of all providers who contribute to care, including social workers and informal caregivers."

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[59] Ibid.
[60] Ibid.
[61] J.A. Sugar, H. Haslem, T. Skaar, T. Brancamp, S.G. Harris, REDUCING AGEISM THROUGH INTERGENERATIONAL SERVICE LEARNING, *Innovation in Aging*, Volume 1, Issue suppl_1, July 2017, Page 826, https://doi.org/10.1093/geroni/igx004.2978
[62] Ashley Lytle, Jamie Macdonald, MaryBeth Apriceno, Sheri R Levy, Reducing Ageism With Brief Videos About Aging Education, Ageism, and Intergenerational Contact, *The Gerontologist*, Volume 61, Issue 7, October 2021, Pages 1164–1168, https://doi.org/10.1093/geront/gnaa167
[63] Ibid.
[64] Andrea Ungar, Antonio Cherubini, Laura Fratiglioni, Vânia de la Fuente-Núñez, Linda P Fried, Marlane Sally Krasovitsky, Mary E Tinetti, Alana Officer, Bruno Vellas, Luigi Ferrucci, Carta of Florence Against Ageism: No Place for Ageism in Healthcare, *The Journals of Gerontology: Series A*, Volume 79, Issue 3, March 2024, glad264, https://doi.org/10.1093/gerona/glad264
[65] Ibid.
[66] Andrea Ungar, Antonio Cherubini, Laura Fratiglioni, Vânia de la Fuente-Núñez, Linda P Fried, Marlane Sally Krasovitsky, Mary Tinetti, Alana Officer, Bruno Vellas, Luigi Ferrucci, Carta of Florence Against Ageism; No Place for Ageism in Healthcare, *Innovation in Aging*, Volume 8, Issue 2, 2024, igad133, https://doi.org/10.1093/geroni/igad133

Research supports opportunities for "a shift of healthcare systems toward integrated person-centered health and social care teams, who receive professional education on the appropriate care of older adults with varying combinations of conditions, life circumstances, and health priorities. Population health approaches need to incorporate goals for disease prevention and health promotion for older adults.[67]"

In, "A Phenomenological Understanding of the Intersection-ality of Ageism and Racism Among Older Adults: Individual-Level Experiences," research findings suggest that studies should incorporate stereotype threat theory through interventions aimed at intentionally reducing racialized ageist stereotypes of mental (in)capability[68]. "Anti-racist and anti-ageist educational initiatives should collaborate and be applied across the life course within intergenerational workplace and health care settings to help prevent the negative impacts of racialized ageism. Future research should explore the intersectional impacts of ageism and racism on specific health outcomes in addition to structural-level interventions.[69]"

Studies show that the helping professions—social work, medicine, public health, counseling, ministry, and others—may be able to reduce the negative effects of ageism on the health of older adults in several ways[70]. Researchers note providers must increase their knowledge, awareness, and intentionality in order to reduce their own perpetration of age discrimination and to identify ageism in their work settings[71]. "Second, helping professionals can model nondiscriminatory attitudes and behaviors for colleagues, clients, friends, and family. Third, individuals, groups, and organizations within the helping professions can increase dialogue about ageism and its potential negative ramifications on the health of older adults by drawing on existing resources… finally, providers can encourage critical analysis of how policies, practices, and cultures within their organizations, their fields, and at the national level may be ageist and can advocate for change using tools such as organizational equity assessments and health impact assessments[72].

11. How can programs advance initiatives that reduce ageism in healthcare and promote older adults' dignity, autonomy, and well-being?

Not only does ageism impact older people, but it creates barriers for all of us as we age at every level of society. Increased education on the impacts of ageism should be targeted in healthcare settings, to caregivers, health professions students, and providers at all levels. The National Center to Reframe Aging is an excellent resource in how we talk about aging and addressing ageism. Tools at the National Center include the "Communication Best Practices: Reframing Aging Initiative Guide to Telling a More Complete Story of Aging" when crafting presentations, press releases, academic papers, letters to the editor, websites, publications, consumer materials, speeches, and other communications. "Frame of Mind Video Series" features 2-minute videos about the reframing aging principles. The National Center's Quick Start Guide reflects the major themes of the National Center to Reframe Aging along with why they are essential to effective framing.

Increased implementation of Age-Friendly Health Systems would help reduce ageism in healthcare and promote the well-being of older people. Transforming primary care practice to improve the health of older adults is a major focus of the Geriatric Workforce Enhancement Program (GWEP). Using the 4Ms of an Age-Friendly Health System (What Matters, Mentation, Medication, and Mobility) as a framework increases providers' knowledge and practice skills, and improving older people's health outcomes[73]. These initiatives are creating increased professional competencies in geriatric care that will help older people maximize their health and wellbeing better support caregivers and families[74].

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[67] Ibid.
[68] Andrew T Steward, Carson M De Fries, Annie Zean Dunbar, Miguel Trujillo, Yating Zhu, Nicole Nicotera, Leslie Hasche, A Phenomenological Understanding of the Intersection-ality of Ageism and Racism Among Older Adults: Individual-Level Experiences, *The Journals of Gerontology: Series B*, Volume 78, Issue 5, May 2023, Pages 880–890, https://doi.org/10.1093/geronb/gbad031
[69] Ibid.
[70] Julie Ober Allen, Ageism as a Risk Factor for Chronic Disease, *The Gerontologist*, Volume 56, Issue 4, August 2016, Pages 610–614, https://doi.org/10.1093/geront/gnu158
[71] Ibid.
[72] Ibid.
[73] Marla Berg-Weger, Erin Emery-Tiburcio, Nina Tumosa, Transforming Primary Care Practice Into Age-Friendly Health Systems, *Innovation in Aging*, Volume 4, Issue Supplement_1, 2020, Page 729, https://doi.org/10.1093/geroni/igaa057.2588
[74] Ibid.

Successfully addressing technology-based ageism in healthcare policy, research, and practice may increase digital engagement that can successfully promote older peoples' social participation, well-being, and autonomy[75]. According to researchers, "over the past two decades, the exponential advancements in digitalization have deluged all areas of everyday life, including work, household, healthcare, and social participation.[76]"

"Based on the recent cutting-edge research on ageism and digital technology in the last five years, researchers believe that the digital divide will not naturally dissolve itself as more technological-savvy cohorts start to age. Failing to address technology-based ageism as a barrier to the successful implementation of digital technology, as recommended earlier, may even widen the digital divide as technology is exponentially developing and evolving[77]."

12. How can intergenerational dialogue and collaboration be fostered to challenge stereotypes about aging and highlight the contributions of older adults to society?

Research supports an integrative model for reducing ageism and promoting intergenerational interaction. "The Positive Education about Aging and Contact Experiences (PEACE) model focuses on two key contributing factors: (a) education about aging including facts on aging along with positive older role models that dispel negative and inaccurate images of older adulthood; and (b) positive contact experiences with older adults that are individualized, provide or promote equal status, are cooperative, involve sharing of personal information, and are sanctioned within the setting[78]."

Further, the core ingredients of education about aging and positive intergenerational contact in the PEACE model are relevant and translatable across many settings (education, employment, healthcare, home) and age groups (children, adolescents, adults) and can be put into practice by educators, healthcare providers, researchers, and others interested in reducing ageism and its negative consequences. With an increasing older population worldwide, a model such as the PEACE model is timely and important[79].

The Age-Friendly University (AFU) initiative takes a systems-level approach and offers guiding principles for advancing age inclusivity, which in turn can combat and inoculate individuals against ageism[80]. "In particular, the principles advocate that older adults be enabled to participate in core educational activities in higher education for personal and professional development and that institutions extend aging education, research on aging, and intergenerational exchange… AFU principles can be applied to disrupt the roots of ageism and age biases, and disparities in healthcare and work environments[81]."

13. What are the social, cultural, and economic factors contributing to ageism in healthcare, and how can they be addressed through public awareness campaigns or policy reforms or other strategies?

Research published in "The Next Critical Turn for Ageism Research: The Intersections of Ageism and Ableism" researchers found that internalized ageism was significantly associated with relational ageism, fear of physical disability, fear of cognitive disability, and affinity for older people[82]. Relational ageism was associated with internalized ageism, relational ableism, fear of physical disability, fear of sensory disability, fear of cognitive disability, and affinity for older people.[83]

According to "Reducing Ageism and Ableism With Brief Videos Providing Education About Aging and Disabilities and Exposure to Positive Intergenerational Contact," ageism and ableism have serious consequences. Both older adults and older adults living with

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[75] Ittay Mannheim, Hanna Köttl, Ageism and (Successful) Digital Engagement: A Proposed Theoretical Model, *The Gerontologist*, Volume 64, Issue 9, September 2024, gnae078, https://doi.org/10.1093/geront/gnae078
[76] Ibid.
[77] Ibid.
[78] Sheri R Levy, Toward Reducing Ageism: PEACE (Positive Education about Aging and Contact Experiences) Model, *The Gerontologist*, Volume 58, Issue 2, April 2018, Pages 226–232, https://doi.org/10.1093/geront/gnw116
[79] Ibid.
[80] Montepare, J. M., & Brown, L. M. (2022). Age-friendly Universities (AFU): Combating and inoculating against ageism in a pandemic and beyond. *Journal of Social Issues*, *78*(4), 1017–1037. https://doi.org/10.1111/josi.12541
[81] Ibid.
[82] Tracey Gendron, Alyssa Camp, Gigi Amateau, Mia Mullen, Kirsten Jacobs, Jenny Inker, Sarah Marrs, The Next Critical Turn for Ageism Research: The Intersections of Ageism and Ableism, *The Gerontologist*, Volume 64, Issue 2, February 2024, gnad062, https://doi.org/10.1093/geront/gnad062
[83] Ibid.

disabilities are negatively stereotyped (e.g., as complainers, incompetent, slow, and burdensome), face poor healthcare treatment[84].

Healthcare educational settings and workplaces are another setting in which ableism and ageism are problematic and where ableism–ageism PEACE model interventions could be effectively integrated in training and in interactions with patients[85].

According to research published in "Exploring the Intersection of Structural Racism and Ageism in Healthcare," structural racism and ageism have long been ingrained in all aspects of U.S. society, including healthcare, exacerbating disparities in social determinants of health, including poor access to healthcare and poor outcomes[86]. The constructs of racism and ageism can have negative effects on health outcomes that can be magnified when race and age intersect[87].

"Fundamental changes need to realize the promise of a just healthcare system include increased representation of people from racially minoritized groups in the healthcare workforce, support for trainees from diverse backgrounds to achieve success in their chosen careers, and inclusion of diverse voices in healthcare policy discussions.[88]"

Age-friendly health is an evidence-based approach to greater health outcomes and critical component of the age-friendly ecosystem, according to "Age-Friendly Ecosystems.[89]" "Aging across the life course is as varied of an experience as humans are. Adults move through life into older adulthood under the effects of a variety of genetics, social determinants, and choices. While older adulthood is often a time of generativity, increased wisdom, and high satisfaction, older people are also exposed to and affected by ageism. Ageism is not only directly damaging to older people but also a costly bias to our communities and society. A variety of interventions have been researched to combat ageism, and many show promise. Fostering age-friendly health care is one solution to existing ageism. Ensuring that all elements of age-friendly health systems are evident in the care of all older people is highly recommended.[90]"

Using the Transitional Care Model as a guide, a recent study focusing on older people transitioning from hospital to home resulted in findings that demonstrate the challenges of patient engagement in the presence of complexity of care[91]. The study also identified challenges with social determinants of health within transitional care and how difficult engagement of older people and caregivers can be to achieve. The study suggests that "future research is needed to understand the factors contributing to and mediating lack of engagement as well as this challenge's impact on health outcomes. Addressing this knowledge gap will inform the design of more effective transitional care interventions.[92]"

14. What roles do education and training for healthcare providers play in addressing implicit or explicit age-related biases, and what are the effective models for such education, both for those currently in training and those now in practice?

There is much opportunity in educating healthcare providers in training and practice ways to address implicit or explicit bias. Research in "Reframing Aging: Effect of a Short-Term Framing Intervention on Implicit Measures of Age Bias" shows that "exposure to a brief, web-based framing intervention can reduce implicit bias against older adults. Participants who read one of three framed messages showed significantly lower levels of implicit bias against older adults, compared with participants in the control condition. In addition, our analysis showed that a framed message about the dynamism of older adults ('*building momentum*')

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[84] Caitlin Monahan, Sheri R Levy, Ashley Lytle, Reducing Ageism and Ableism With Brief Videos Providing Education About Aging and Disabilities and Exposure to Positive Intergenerational Contact, *The Gerontologist*, Volume 64, Issue 12, December 2024, gnae137, https://doi.org/10.1093/geront/gnae137

[85] Ibid.

[86] Farrell TW, Hung WW, Unroe KT, et al. Exploring the intersection of structural racism and ageism in healthcare. *J Am Geriatr Soc*. 2022; 70(12): 3366-3377. doi:10.1111/jgs.18105

[87] Ibid.

[88] Ibid.

[89] Friberg-Felsted, K., D'Antonio, P.M. (2024). Age-Friendly Health. In: Chang Greer , V., Edelman, L.S. (eds) Age-Friendly Ecosystems. SpringerBriefs in Public Health. Springer, Cham. https://doi.org/10.1007/978-3-031-68361-9_5

[90] Ibid.

[91] Claire Regan, Karen Hirschman, Rachel Harding, Molly McHugh, Onome Osokpo, Kathleen McCauley, Elizabeth Shaid, Mary Naylor, 1. ENGAGEMENT: A PRIORITY NEED IN CARE TRANSITIONS EXPERIENCED BY OLDER ADULTS AND CAREGIVERS, *Innovation in Aging*, Volume 8, Issue Supplement_1, December 2024, Page 1177, https://doi.org/10.1093/geroni/igae098.3771

[92] Ibid.

reduced implicit bias relative to an unframed aging message, providing evidence that experimental effects were attributable to the frame itself, not to general content about aging[93]."

Policies should be developed and implemented to ensure that aging becomes an integral part of any educational curriculum for health and social care professionals[94]. Health and social care providers should also have the opportunity to participate in intergenerational activities involving older people, as this engagement has been demonstrated to effectively reduce ageism[95]. According to "Carta of Florence Against Ageism; No Place for Ageism in Healthcare," most health and social care workers "have not received educational opportunities around aging and older people and are therefore unprepared to respond to the preferences and healthcare and prevention needs of the older patients that they will eventually treat.[96]"

15. How does the effect of ageism differ across different population groups?

Ageist policies and practices that affect older people experiencing homelessness have been documented within the homelessness and housing sector, and the community more broadly[97]. According to "Intersections of Ageism and Homelessness Among Older Adults: Implications for Policy, Practice, and Research," within the homelessness sector, services, including healthcare, have long been criticized for prioritizing the needs of and support for younger homeless populations, while neglecting the unique needs of older people.[98]"

Older Black adults with cancer suffer a "double disadvantage" to their health due to the compounding effects of ageism and racism. This "double disadvantage" further fuels the disparities in cancer-related mortality observed for this population[99].

In "Scoping Review on Ageism against Younger Populations," evidence suggests that ageism is present across institutions and prominent throughout the life course, including in early life stages[100]. "It also shows that younger people might be more likely to report perceived ageism compared to other age groups. Determinants of ageism against younger people also received a substantial amount of attention, with most studies focusing on interpersonal characteristics that may affect people's interaction with younger people (e.g., the respondent's personality traits)[101]."

Thank you for the opportunity to provide input. If you have any questions, please contact Patricia D'Antonio, Vice President of Policy and Professional Affairs at pdantonio@geron.org or 202-587-5880 or Jordan Miles, Director of Policy at jmiles@geron.org or 202-587-5884.

Sincerely,

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[93] Daniel S Busso, Andrew Volmert, Nathaniel Kendall-Taylor, Reframing Aging: Effect of a Short-Term Framing Intervention on Implicit Measures of Age Bias, The Journals of Gerontology: Series B, Volume 74, Issue 4, May 2019, Pages 559–564, https://doi.org/10.1093/geronb/gby080

[94] Andrea Ungar, Antonio Cherubini, Laura Fratiglioni, Vânia de la Fuente-Núñez, Linda P Fried, Marlane Sally Krasovitsky, Mary Tinetti, Alana Officer, Bruno Vellas, Luigi Ferrucci, Carta of Florence Against Ageism; No Place for Ageism in Healthcare, *Innovation in Aging*, Volume 8, Issue 2, 2024, igad133, https://doi.org/10.1093/geroni/igad133

[95] Ibid.

[96] Ibid.

[97] Rachel Weldrick, Sarah L Canham, Intersections of Ageism and Homelessness Among Older Adults: Implications for Policy, Practice, and Research, *The Gerontologist*, Volume 64, Issue 5, May 2024, gnad088, https://doi.org/10.1093/geront/gnad088

[98] Ibid.

[99] Shakira Grant, LEVERAGING THE COMMUNITY AS PARTNERS TO ADVANCE CANCER RESEARCH IN SOCIALLY DIVERSE OLDER ADULT POPULATIONS, *Innovation in Aging*, Volume 7, Issue Supplement_1, December 2023, Page 228, https://doi.org/10.1093/geroni/igad104.0752

[100] de la Fuente-Núñez, V., Cohn-Schwartz, E., Roy, S., & Ayalon, L. (2021). Scoping Review on Ageism against Younger Populations. *International Journal of Environmental Research and Public Health*, *18*(8), 3988. https://doi.org/10.3390/ijerph18083988

[101] Ibid.