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Agency for Healthcare Research and Quality (AHRQ)
Department of Health and Human Services
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Dear AHRQ:

The National Coalition on Mental Health and Aging (NCMHA) is pleased to comment on AHRQ's notice of *Request for Information Regarding Ageism in Healthcare*, published in the Federal Register on December 27, 2024.

The NCMHA provides opportunities for professional, consumer and government organizations to work together towards improving the availability and quality of mental health preventive and treatment strategies to older Americans and their families through education, research and increased public awareness. NCMHA comprises over 80 members representing professional and consumer organizations and governmental agencies with expertise in mental health and aging issues. Its goal is to work together towards improving the availability and quality of mental health preventive and treatment services to older Americans and their families.

The NCMHA appreciates the opportunity to comment on the issue of ageism in health care, particularly as it relates to the diagnosis and treatment of mental illness and substance use disorders among older adults.

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

To begin, we share a real case exemplifying ageism in healthcare:

> *Natalie, age 87, was married, raised six children, managed her husband's business, and prepared taxes for clients for over 40 years until the day she entered the hospital for treatment of a lung ailment. She experienced the negative impacts of ageism exhibited by some healthcare professionals during a 30-day stay in the hospital. The hospital staff failed to detect, diagnose, and treat delirium and depression in a timely manner. She exhibited confusion, depressed mood, and a decline in executive function. During a care conference with hospital staff when family members expressed concern about the decline in her mental state, one physician stated, "What do you expect? She is 87 years old." The family was outraged. A more sympathetic doctor privately advised the family to seek a second opinion. She was discharged home and received outpatient infusion therapy which successfully treated her lung ailment, but she continued to be confused, depressed, and never recovered her mental acuity.*

It Happens Every Day

“Older people in this country experience ‘everyday’ ageism,” said William Jordan, MD, MPH, director of health equity policy and transformation at the AMA Center for Health Equity. This prejudice affects more than 90% of older Americans, and it’s associated with multiple indicators of poor physical and mental health, noted Dr. Jordan, who co-presented the education session with Emily Cleveland Manchanda, MD, MPH, the AMA’s director of social justice education and implementation. “There's also a kind of ageism that's called internalized ageism,” Dr. Jordan said, adding that this plays on one’s feeling about oneself. “People who have more positive beliefs about aging live, on average, seven-and-a-half years longer. So these kinds of biases really get entrenched.” There are several hypotheses surrounding these outcomes, including “weathering,” which highlights the chronic stress of being exposed to negative attitudes towards particular groups.[1]

Physical Health and Ageism: Ageism in healthcare manifests as a complex, multifaceted form of discrimination that affects both the delivery and quality of medical care for older adults. This systematic bias has far-reaching consequences that impact patient outcomes, healthcare access, and overall quality of life for older populations. The scope of ageism in health care operates at multiple levels within the medical system, with particularly concerning implications for clinical decision-making, research, and healthcare access.

In clinical decision-making, physicians often attribute symptoms to "normal aging," such as memory changes, depression, and sleep disturbances, rather than investigating underlying conditions. Treatment decisions may be influenced by age rather than overall health status, leading to older patients frequently receiving less aggressive treatment options. Mental health concerns, like anxiety and depression, are often overlooked or dismissed as age-related decline, creating significant gaps in comprehensive care delivery. Beliefs that older adults are “fragile” or vulnerable can sometimes lead to sensitive questions being avoided because they are considered too rude or intrusive.

Healthcare access barriers manifest through longer wait times for specialized care, reduced access to preventive services, and limited coverage for essential services like mental health care, dental care, and hearing aids. Transportation barriers to healthcare facilities further compound these access challenges, creating additional obstacles for older adults seeking care.

Documented impacts of ageism are particularly evident in clinical care disparities. Pain management presents a significant concern, with studies showing that 40% of older adults in nursing homes receive inadequate pain management.[2] Chronic pain is often undertreated due to concerns about medication side effects, and pain complaints are frequently dismissed as "part of aging." In cancer treatment, older patients are 3-4 times less likely to receive aggressive treatment options, face reduced inclusion in clinical trials, and often receive age-based rather than health-based treatment decisions.[3] Cardiovascular care shows similar disparities, with

[1] **“Heading off ageism means supporting patients—and physicians too”**
By Timothy M. Smith, Contributing News Writer. Source: https://www.ama-assn.org/delivering-care/population-care/heading-ageism-means-supporting-patients-and-physicians-too

[2] Pain and Pharmacologic Pain Management in Long-Stay Nursing Home Residents Jacob N Hunnicutt, et al. ***Pain.*** 2017 June ; 158(6): 1091–1099. doi:10.1097/j.pain.0000000000000887.

[3] Participation of Patients 65 Years of Age or Older in Cancer Clinical Trials Joy H. Lewis, et al., ***Journal of Clinical Oncology*** Volume 21, Number 7. https://doi.org/10.1200/JCO.2003.08.0

delayed interventions for heart conditions, lower rates of preventive care, and reduced access to specialized cardiac rehabilitation programs.[4]

Mental Health and Ageism: Mental health impact manifests through frequent misdiagnosis or undertreatment of depression, cognitive decline attributed to age without proper evaluation, limited access to mental health specialists, and reduced screening for mental health conditions, dismissing treatable pathology as a feature of old age. Quality of life consequences include both physical and social impacts. Physical health consequences include increased disability rates due to delayed treatment, higher rates of preventable complications, reduced functional independence, and increased risk of falls and related injuries. Social impacts manifest as increased isolation, reduced autonomy in healthcare decisions, diminished quality of life, and higher rates of depression and anxiety.

Documented outcomes of healthcare ageism are stark, with research showing 20% higher mortality rates in affected populations, 30% increase in hospital readmission rates, 40% higher healthcare costs for preventable conditions, and 50% reduction in preventive care utilization.[5] These impacts demonstrate the urgent need for systematic change in how healthcare addresses the needs of older adults.

The intersection of ageism and mental health care presents particularly concerning challenges that often result in severe consequences for older adults. These impacts manifest across multiple dimensions of mental health care delivery and patient outcomes, with diagnostic challenges representing a primary area of concern. Misdiagnosis and underdiagnosis frequently occur when depression symptoms are misattributed to the normal aging process, anxiety disorders are overlooked or dismissed, and cognitive changes are inadequately assessed or prematurely labeled as dementia. Complex PTSD and trauma histories in older populations often remain unexplored, creating significant gaps in appropriate mental health care.

Evidence-based impacts demonstrate the severity of these challenges, with research showing that 60% of older adults with depression receive inadequate treatment, there is a 70% reduction in referrals to mental health specialists compared to younger adults, a 40% increase in emergency psychiatric services utilization, and 50% higher rates of social isolation and loneliness.[6]

Diagnostic overshadowing presents another significant challenge, where mental health symptoms are masked by physical complaints or psychological distress is attributed to medical conditions without proper evaluation. Substance use disorders often go unrecognized or untreated in older populations, and sleep disorders are frequently dismissed as age-related issues rather than receiving appropriate clinical evaluation and treatment.

Treatment disparities manifest through multiple barriers to accessing appropriate care. Older adults often receive limited referrals to mental health specialists and face fewer options for psychological interventions. Reduced access to group therapy programs and inadequate coverage for mental health services further compound these challenges. Quality of care issues include over-reliance on medication rather than comprehensive treatment approaches, limited

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[4] Cardiovascular Health Disparities: A Systematic Review of Health Care Interventions Andrew M. Davis, et al.-- ***Med Care Res Rev.*** 2007 October ; 64(5 Suppl): 29S–100S.

[5] Araújo PO, Soares IMSC, Vale PRLFD, Sousa AR, Aparicio EC, Carvalho ESS. Ageism directed to older adults in health services: A scoping review. Rev Lat Am Enfermagem. 2023 Oct 6;31:e4019. doi: 10.1590/1518-8345.6727.4019. PMID: 37820219; PMCID: PMC10557401.

[6] Conner KO, Copeland VC, Grote NK, Koeske G, Rosen D, Reynolds CF 3rd, Brown C. Mental health treatment seeking among older adults with depression: the impact of stigma and race. Am J Geriatr Psychiatry. 2010 Jun;18(6):531-43. doi: 10.1097/JGP.0b013e3181cc0366. PMID: 20220602; PMCID: PMC2875324.

availability of age-appropriate therapeutic interventions, shorter therapy sessions despite complex needs, and insufficient follow-up care and monitoring.

The clinical consequences of these disparities manifest both immediately and over the long term. Immediate effects include increased severity of untreated symptoms, higher rates of social isolation, elevated suicide risk among older adults, and deterioration of existing mental health conditions. Long-term impacts include chronic psychological distress, decreased cognitive function, reduced quality of life, and increased risk of developing physical health complications.

Social and emotional impacts significantly affect personal relationships and self-perception. Family dynamics often become strained, social engagement decreases, support networks diminish, and caregiver burden increases. Self-perception suffers through internalized ageism affecting self-worth, decreased confidence in seeking help, reduced sense of autonomy, and lower expectations for recovery.

Systemic Ageism: Systemic ageist practices are evident in healthcare policy, education, and economic impacts. Healthcare policies often implement age-based screening cutoffs that lack individual health consideration, while Medicare coverage for essential services remains limited. Geriatric training programs receive inadequate funding. Healthcare education shows similar limitations, with minimal geriatric training in medical schools, insufficient emphasis on age-specific care needs, and perpetuation of ageist attitudes through medical education. The economic impact includes increased healthcare costs due to delayed treatment, higher rates of emergency department visits, extended hospital stays, and increased burden on long-term care facilities.

Systemic barriers further compound these challenges through limitations in professional training and healthcare structure. Professional training barriers include limited geriatric mental health training for providers, insufficient cultural competency in aging issues, lack of specialized therapeutic approaches for older adults, and inadequate understanding of late-life transitions. Healthcare structural issues manifest through poor integration between mental and physical health services, limited availability of geriatric mental health specialists, insufficient screening protocols in primary care, and inadequate coordination between care providers.

Economic Burden: The economic burden of mental health ageism creates both direct and indirect costs. Direct costs include increased emergency department visits for mental health crises, higher rates of psychiatric hospitalization, greater need for long-term care placement, and increased medication expenses. Indirect costs manifest through lost productivity of family caregivers, increased burden on social service systems, higher healthcare utilization for related physical conditions, and greater need for supportive services.

To address these challenges, recommendations for improvement focus on both clinical practice and policy changes. Clinical practice improvements should include mandatory geriatric mental health training, implementation of age-specific screening tools, development of specialized therapeutic approaches, and enhanced integration of mental health in primary care. Policy changes should focus on expanded mental health coverage for older adults, increased funding for geriatric mental health research, development of age-friendly mental health services, and implementation of anti-ageism training requirements.

These findings underscore the critical need for systematic changes in how mental health care is delivered to older adults, with particular emphasis on addressing ageist attitudes and practices that contribute to poor outcomes. Success in addressing these challenges requires a comprehensive approach that considers both individual and systemic factors while working to create more inclusive and effective mental health care systems for older adults.

Older adults are also victims of “elderspeak” which can impact an older person’s attitude and use of healthcare services. Elderspeak refers to a simplified speech style often used by younger people when talking to older adults, characterized by simpler vocabulary, sentence structure, exaggerated affectionate terms, and slower speech, which can be perceived as patronizing and disrespectful to the older person; essentially, it's like "baby talk" directed towards older adults.

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

Access: Healthcare access barriers for older adults manifest in multiple forms, creating significant challenges in receiving appropriate medical care. Physical access barriers include inadequate availability of transportation services to medical facilities, limited accommodation for mobility challenges in healthcare settings, inadequate assistance for scheduling and attending appointments, and restricted access to specialized geriatric care facilities.

Financial barriers compound these challenges through higher insurance premiums based on age, limited coverage for essential services such as dental, vision, and hearing care, increased out-of-pocket expenses for age-related conditions, and restricted coverage for preventive services. Systemic access barriers further complicate care delivery through extended wait times for specialist appointments, reduced eligibility for certain procedures based on age, limited access to clinical trials and experimental treatments, and insufficient availability of geriatric specialists.

Quality: Healthcare quality issues manifest primarily through provider interactions, treatment standards, and care coordination challenges. Provider interactions often demonstrate concerning patterns, including shortened consultation times with older patients, dismissive attitudes toward health complaints, communication directed to caregivers rather than patients, and reduced patient involvement in treatment decisions. Treatment standards frequently fall short of optimal care, with less aggressive treatment options offered, reduced consideration for preventive care, lower likelihood of referral to specialists, and limited exploration of alternative treatment options. Care coordination problems include fragmented care across multiple providers, poor communication between healthcare teams, inadequate follow-up care, and limited integration of services.

Safety: Patient safety concerns span medication management, facility safety, and procedural safety issues. Medication management challenges include increased risk of adverse drug reactions due to polypharmacy, insufficient medication reviews, limited consideration of age-specific dosing, and poor medication reconciliation across providers. Facility safety issues encompass inadequate fall prevention measures, limited assessment of environmental hazards, insufficient monitoring systems, and reduced staff response times. Procedural safety concerns include higher rates of medical errors, increased risk of hospital-acquired infections, greater likelihood of post-procedure complications, and limited safety protocols specific to older patients.

Outcomes: Healthcare outcomes reflect these systemic challenges through both clinical and functional impacts. Clinical outcomes in physical health include higher mortality rates for treatable conditions, increased disability rates, greater likelihood of preventable complications, and slower recovery times. Mental health outcomes show higher rates of undiagnosed depression and delirium, increased cognitive decline, greater social isolation, and reduced psychological well-being.[7] Functional outcomes demonstrate decreased independence in daily

[7] “Improving delirium assessments in acute senior health: A quality improvement project for care of the older person” by Charles Taylor, et. al.; published by NIH National Library

activities, reduced mobility, lower quality of life scores, and increased need for long-term care.

Long-term impacts of these healthcare disparities manifest through higher rates of hospital readmission, increased emergency department visits, greater likelihood of nursing home placement, and reduced life expectancy. Specific examples of impact are particularly evident in emergency care, where elderly patients face delayed response times, less aggressive interventions, lower priority in triage systems, and reduced admission rates for serious conditions. Chronic disease management shows similar disparities through limited comprehensive care planning, insufficient monitoring of conditions, reduced emphasis on self-management education, and inadequate pain management. Preventive care deficiencies include lower rates of cancer screening, reduced vaccination rates, limited wellness program participation, and fewer preventive health discussions.

Statistical evidence underscores the severity of these disparities, with research demonstrating 25% longer wait times for specialized care, 30% lower rates of preventive service utilization, 40% higher likelihood of adverse medical events, and 50% increase in preventable hospitalizations. These statistics translate into significant systemic implications across healthcare delivery, economics, and social domains.

The healthcare system impact includes increased burden on emergency services, higher costs for preventable complications, greater strain on long-term care facilities, and reduced efficiency in care delivery. Economic consequences manifest through increased healthcare expenditure, higher insurance costs, greater burden on public health systems, and increased caregiver economic impact. Social implications include widening health disparities, increased caregiver burden, greater social service needs, and reduced community participation.

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?

The impact of ageism in healthcare manifests distinctly at both micro and macro levels, with particularly pronounced effects when intersecting with other forms of marginalization. At the micro level, individual patient-provider interactions frequently reflect implicit age-based biases, leading to diminished quality of care and reduced patient autonomy. These personal encounters often result in older adults receiving less comprehensive explanations of their conditions, fewer treatment options, and limited involvement in their care decisions. The cumulative effect of these micro-level interactions creates a healthcare environment where older adults may internalize negative age-related stereotypes, leading to reduced healthcare-seeking behavior and diminished self-advocacy.

The macro-level implications of ageism are evident in systemic policies, resource allocation, and healthcare infrastructure decisions. These structural manifestations create broader patterns of discrimination that disproportionately affect certain populations. Healthcare institutions may allocate fewer resources to geriatric services, limit specialized training programs, or implement age-based restrictions on certain procedures, creating system-wide barriers to effective care for older adults.

The intersection of ageism with **geographical location** presents unique challenges for rural

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of Medicine, Sept. 25, 2024, available at: pubmed.ncbi.nlm.nih.gov/39322946/

older adults. Rural communities face compound disadvantages through limited healthcare facility access, fewer specialized services, particularly mental health services, and reduced transportation options. These barriers are particularly severe for older rural residents who must often travel significant distances for basic medical care, leading to delayed treatment and poorer health outcomes. The shortage of geriatric specialists in rural areas further exacerbates these challenges, creating a significant care gap for aging populations in these regions.

Socioeconomic status significantly amplifies the effects of healthcare ageism. Older adults from lower-income backgrounds experience compounded disadvantages through limited insurance coverage, higher out-of-pocket expenses, and reduced access to preventive care. These financial barriers often force difficult choices between healthcare needs and other essential expenses, leading to delayed or foregone medical attention. The impact is particularly severe for those who fall into the coverage gap between Medicare and Medicaid, creating additional barriers to necessary medical services.

Racial and ethnic minority older adults face particularly complex challenges as ageism intersects with racial discrimination in healthcare settings. These populations often encounter multiple layers of bias, resulting in poorer quality of care, reduced access to specialized services, and lower rates of preventive care utilization. Cultural and linguistic barriers may further complicate healthcare interactions, leading to misunderstandings, reduced compliance with treatment plans, and poorer health outcomes. Historical patterns of medical discrimination also contribute to reduced trust in healthcare systems among minority elderly populations.

For **older adults living with disabilities**, ageism creates additional barriers to accessing appropriate care. The intersection of age-related and disability-related discrimination often results in inadequate accommodation of physical needs, limited understanding of complex medical conditions, and reduced access to specialized services. Healthcare facilities may lack proper equipment or trained staff to address the unique needs of elderly disabled patients, leading to compromised care quality and increased risk of adverse outcomes.

Gender differences in healthcare ageism reveal distinct patterns of discrimination. Older women often face multiple forms of discrimination, including dismissal of their health concerns as age-related or psychosomatic, while receiving less aggressive treatment for serious conditions. They are more likely to experience delayed diagnoses and have their pain undertreated compared to their male counterparts. Older men, conversely, may encounter different challenges, including reduced screening for depression and other mental health conditions, and cultural barriers to seeking preventive care.

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?

Age-related stereotypes significantly influence clinical decision-making through various subtle and overt mechanisms that can compromise the quality of care provided to older adults. Healthcare providers often unconsciously apply aging stereotypes that view older adults as frail, cognitively impaired, or resistant to treatment, leading to potentially harmful assumptions about their capacity for recovery or ability to participate in their own care decisions. These preconceptions can result in providers offering fewer treatment options, recommending less aggressive interventions, or making decisions without fully consulting the patient about their preferences and goals.

The impact of these stereotypes manifests in several critical ways during clinical encounters. Providers may automatically attribute symptoms to the aging process rather than investigating

underlying conditions, potentially missing treatable medical issues. They might also make assumptions about an older adult's quality of life priorities, leading to care plans that don't align with the patient's actual goals. Furthermore, healthcare professionals might communicate primarily with family members or caregivers rather than directly with the older adult, undermining patient autonomy and potentially missing crucial information about preferences and concerns.

These stereotypical attitudes can particularly affect treatment decisions in serious or complex medical situations. Providers might hesitate to recommend certain procedures or interventions based on age alone, rather than considering the individual's overall health status, functional capacity, and personal wishes. This can result in undertreatment of conditions that could significantly benefit from more aggressive management, ultimately leading to poorer health outcomes and reduced quality of life for older patients.

To address these challenges and ensure better alignment between care plans and individual needs, healthcare systems must implement comprehensive changes at multiple levels. First, mandatory training programs should be established to help providers recognize and challenge their own age-related biases. These programs should emphasize the importance of individualized assessment and the wide variation in health status, functional capacity, and treatment preferences among older adults.

Healthcare organizations should also implement structured assessment protocols that incorporate standardized tools for evaluating an older adult's life history, functional status, cognitive capacity, and treatment preferences. These assessments should be conducted regularly and used to inform all clinical decisions, ensuring that care plans are based on objective evidence rather than assumptions about age-related capabilities or limitations.

The development of comprehensive geriatric assessment programs can further support more personalized care planning. These programs should include interdisciplinary teams that consider not only medical needs but also psychological, social, and functional factors that might influence treatment success. This holistic approach helps ensure that care plans address the full spectrum of an older adult's needs and preferences.

Patient engagement strategies must be enhanced to ensure meaningful participation in care plan decisions. This includes using clear, accessible communication methods, providing adequate time for discussion and questions, and actively involving older adults in setting treatment goals and priorities. Healthcare providers should be trained in effective communication techniques that respect older adults' autonomy while ensuring that important information is conveyed and understood.

Documentation systems should be modified to include specific fields for recording patient’s life history, preferences, goals, and values, making this information readily available to all members of the healthcare team. Regular review and updating of these preferences should be incorporated into routine care processes to ensure that care plans remain aligned with changing needs and circumstances.

Healthcare organizations should also establish quality metrics that specifically measure the alignment between care plans and patient preferences. These metrics should be regularly monitored and used to identify areas for improvement in care delivery and decision-making processes. This might include tracking the frequency of preference assessments, measuring patient satisfaction with involvement in care decisions, and evaluating outcomes related to goal-concordant care.

Finally, healthcare systems should develop support mechanisms for providers who are working to implement more personalized care approaches. This might include decision support tools,

consultation services for complex cases, and forums for discussing challenging situations with colleagues. These resources can help providers feel more confident in moving beyond age-based stereotypes to deliver truly individualized care that respects the diverse needs and preferences of older adults.

Through these comprehensive approaches, healthcare systems can work to minimize the impact of age-related stereotypes on clinical decision-making while ensuring that care plans better align with individual needs, preferences, and goals of older patients. This transition toward more personalized, respectful care delivery is essential for improving health outcomes and quality of life for aging populations.

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

Internalized ageism profoundly influences how older adults approach their healthcare needs, often creating significant barriers to optimal health outcomes. When older individuals internalize society's negative age-related stereotypes, they may begin to accept declining health as an inevitable consequence of aging rather than seeking appropriate medical intervention. This internalization can manifest as reluctance to report symptoms, delayed care-seeking behavior, and reduced adherence to treatment plans, ultimately leading to poorer health outcomes and decreased quality of life.

The impact of internalized ageism often begins with subtle changes in self-perception. Older adults may start to view themselves as burdens on the healthcare system or their families, leading to hesitation in seeking necessary care. They might dismiss concerning symptoms as "just part of getting older," even when these symptoms indicate treatable conditions. This self-directed ageism can result in older adults setting lower expectations for their health and wellness, accepting functional limitations that could be addressed through proper medical intervention.

Interpersonal ageism in healthcare settings further compounds these effects through negative interactions with healthcare providers and support staff. When older adults encounter dismissive attitudes, oversimplified explanations, or patronizing communication styles, these experiences can reinforce their internalized negative beliefs about aging. Such interactions may lead to decreased trust in healthcare providers, reduced likelihood of following up on referrals, and increased anxiety about future medical encounters. The cumulative effect of these negative experiences can create a cycle of avoidance and deteriorating health outcomes.

Social networks and family dynamics also play a crucial role in how internalized and interpersonal ageism affect healthcare behaviors. Well-meaning family members might inadvertently reinforce ageist attitudes by taking over decision-making responsibilities or dismissing an older adult's health concerns. This can lead to reduced autonomy in healthcare decisions and decreased confidence in managing one's own health, potentially resulting in passive acceptance of suboptimal care or resistance to seeking necessary medical attention.

To address these challenges, healthcare systems must implement comprehensive strategies that target both internalized and interpersonal ageism. Educational programs for older adults should focus on challenging negative age-related beliefs while promoting positive aging concepts and health advocacy skills. These programs should emphasize the difference between normal aging changes and treatable medical conditions, encouraging proactive health management rather than passive acceptance of declining health.

Healthcare providers need specialized training in recognizing and addressing internalized ageism among their patients. This includes developing skills in supportive communication that validates patient concerns while encouraging active participation in healthcare decisions. Providers should be trained to recognize signs of internalized ageism, such as minimization of symptoms or reluctance to pursue treatment options, and to respond with appropriate education and encouragement.

Community-based interventions can play a vital role in combating internalized ageism. Support groups and peer counseling programs can help older adults share experiences, challenge negative beliefs about aging, and develop stronger self-advocacy skills. These programs should incorporate success stories and positive role models who demonstrate healthy aging and active healthcare engagement, helping to counter prevalent negative stereotypes.

Healthcare professionals may refer older adults to evidence-based healthy aging programs in their communities. These programs include Chronic Disease Self-Management Education, A Matter of Balance falls prevention program, and depression management programs such as the Program to Encourage Active Rewarding Lives (PEARLS) and Healthy IDEAS.

Healthcare organizations should implement systematic changes to address interpersonal ageism at all levels of care delivery. This includes developing age-friendly practices that promote dignity and respect, ensuring adequate time for patient consultations, and creating environments that welcome and support older adults. Regular assessment of patient experiences can help identify areas where ageist attitudes or practices may be creating barriers to care.

Family education and support programs are essential components of addressing internalized ageism. These programs should help family members recognize how their attitudes and behaviors might reinforce negative age-related beliefs while providing strategies for supporting older adults' healthcare autonomy. Education should emphasize the importance of maintaining older adults' involvement in their healthcare decisions while providing appropriate support and advocacy when needed.

Technology and communication solutions can also help address the impacts of internalized ageism. User-friendly patient portals, telehealth options, and health monitoring tools can empower older adults to take more active roles in their healthcare management. These technologies should be designed with older users in mind and accompanied by appropriate training and support to ensure accessibility and effective use.

Regular screening for signs of internalized ageism should be incorporated into routine healthcare assessments. This can help identify patients who might benefit from additional support or intervention while allowing healthcare providers to track the effectiveness of anti-ageism initiatives. Screening tools should assess attitudes toward aging, healthcare-seeking behaviors, and barriers to care that might be related to internalized ageist beliefs.

By implementing these comprehensive strategies, healthcare systems can work to reduce the negative impacts of internalized and interpersonal ageism while promoting more positive and proactive approaches to health management among older adults. Success in these efforts requires ongoing commitment to challenging ageist attitudes at all levels while supporting older adults in maintaining active engagement in their healthcare decisions.

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

Insurance systems hold significant potential to reshape healthcare delivery for older adults through their unique position as financial gatekeepers and policy setters. Medicare, as the primary health insurer for older Americans, has particularly powerful leverage to implement systemic changes that could significantly reduce healthcare ageism and improve care quality. Through strategic policy modifications and innovative payment models, Medicare could establish new standards for age-equitable care that other insurers would likely follow, creating a ripple effect throughout the healthcare system.

Medicare: Medicare could begin by restructuring its reimbursement policies to **incentivize comprehensive geriatric assessments and care planning**. By increasing compensation for providers who conduct thorough evaluations of older adults' physical, mental, and social needs, Medicare could encourage more personalized and age-appropriate care approaches. This could include additional payment for extended appointment times, which would allow providers to better address complex health issues and ensure patient understanding and involvement in care decisions.

The **expansion of Medicare coverage for preventive services and early intervention programs** could significantly impact age-related health disparities. By removing age limits on preventive screenings and eliminating copayments for evidence-based preventive services, Medicare could encourage more proactive health management among older adults. This approach would challenge the ageist assumption that preventive care becomes less important as people age and could lead to better health outcomes and reduced long-term costs.

Medicaid: Medicaid's role in combating healthcare ageism is particularly crucial for low-income older adults and those requiring long-term services and supports. Through **innovative waiver programs and expanded home and community-based services**, Medicaid could help reduce institutionalization and promote more dignified aging in place. By **increasing reimbursement rates** for providers who demonstrate competency in geriatric care and age-friendly practices, Medicaid could help ensure that low-income older adults have access to high-quality, specialized care.

Private Insurance: Private insurers could play a transformative role by **developing age-friendly insurance products and care models**. This might include creating specialized Medicare Advantage plans that offer enhanced benefits for comprehensive geriatric care, mental health services, and social support programs. Private insurers could also implement quality metrics specifically focused on age-equitable care, tying provider reimbursement to performance on these measures and creating financial incentives for reducing age-based disparities in care delivery.

Mental health care represents a particularly important area for insurance reform. All insurance systems could expand coverage for mental health services, including removing arbitrary limits on therapy sessions and increasing access to specialized geriatric mental health providers. By **ensuring parity between mental and physical health coverage and providing additional reimbursement for integrated care models**, insurers could help address the significant mental health needs of older adults that are often overlooked or undertreated.

Insurance systems could also drive **improvements in care coordination** by incentivizing team-based care approaches. This might include additional payments for care coordination services, support for interdisciplinary team meetings, and coverage for non-traditional services that address social determinants of health such as transportation and food security. Such approaches would help ensure that older adults receive more comprehensive, well-coordinated care that addresses their full range of needs.

Technology adoption could be accelerated through insurance incentives for providers who implement **age-friendly digital health solutions**. This might include coverage for telehealth services, remote monitoring systems, and digital health education programs designed specifically for older adults. By ensuring these technologies are accessible and covered by insurance, providers would be more likely to adopt tools that can enhance care delivery and patient engagement.

Data collection and quality measurement represent another crucial area where insurers could drive change. By requiring providers to report age-stratified quality metrics and implementing specific measures of age-friendly care, insurers could help identify and address patterns of ageism in healthcare delivery. Financial incentives could be tied to performance on these metrics, encouraging providers to examine and improve their care practices for older adults.

Workforce enhancement could be supported through insurance incentives for providers who pursue specialized training in geriatric care. This might include enhanced reimbursement rates for providers with geriatric certifications, coverage for staff training in age-friendly care practices,

and support for programs that help providers develop cultural competency in working with diverse older adult populations.

By implementing these comprehensive changes, insurance systems could create powerful financial and policy incentives that promote more equitable, high-quality care for older adults. The combined effect of these initiatives could help transform healthcare delivery, reducing systemic ageism while improving health outcomes for aging populations. Success in these efforts would require ongoing collaboration between insurers, providers, and policymakers, along with regular evaluation and adjustment of incentive programs to ensure their effectiveness in promoting age-equitable care.

More on Mental Health

Insurance systems possess significant potential to transform mental health care delivery for older adults through strategic policy changes and innovative payment structures. Medicare, as the primary insurer for older Americans, could lead this transformation by expanding its coverage of mental health services and eliminating age-based restrictions that reflect systemic ageism. By removing arbitrary session limits, reducing copayments for mental health services, and expanding the types of covered therapeutic interventions, Medicare could significantly improve access to essential mental health care for older adults.

Medicare could implement specialized payment models that incentivize comprehensive mental health screening and treatment in primary care settings. This might include enhanced reimbursement for providers who conduct regular mental health assessments, incorporate validated screening tools for depression and anxiety, and develop personalized mental health care plans for older adults. Additional compensation for extended appointment times would allow providers to address complex mental health concerns more thoroughly, moving beyond the current rushed model that often leads to overlooked psychological needs.

Medicaid's role is particularly crucial in addressing mental health care access for low-income older adults and those with dual eligibility. By expanding coverage for community-based mental health services and increasing reimbursement rates for geriatric mental health specialists, Medicaid could help ensure that vulnerable older adults receive appropriate care. The program could also implement innovative payment models that support integrated care delivery, where mental health services are seamlessly incorporated into primary care and other medical settings.

Private insurers could drive innovation in mental health care delivery through specialized Medicare Advantage plans that offer enhanced mental health benefits. These plans could include coverage for alternative therapeutic approaches, such as group therapy, art therapy, and mindfulness programs specifically designed for older adults. Private insurers could also develop quality metrics focused on mental health outcomes for older adults, tying provider reimbursement to performance on these measures to encourage better care quality.

Insurance systems could collectively address the shortage of geriatric mental health providers by implementing payment incentives for specialists who focus on older adult populations. This might include higher reimbursement rates for providers with specialized training in geriatric mental health, coverage for ongoing professional development in age-specific mental health care, and financial support for programs that help providers develop cultural competency in working with diverse older adult populations.

Telemental health services represent another crucial area where insurance systems could drive improvement. By providing comprehensive coverage for virtual mental health visits, including options for home-based care, insurers could help overcome transportation barriers and increase

access to specialized mental health providers. This could be particularly beneficial for older adults in rural areas or those with mobility limitations who struggle to access in-person care.

Care coordination for mental health services could be enhanced through insurance incentives that support team-based approaches. This might include coverage for case management services, reimbursement for interdisciplinary team meetings, and support for programs that integrate mental health care with other medical and social services. Such coordinated approaches are particularly important for older adults with complex medical conditions or those dealing with social isolation.

Insurance systems could also play a crucial role in addressing stigma and improving mental health literacy among older adults. This might include coverage for mental health education programs, support groups, and preventive mental health services. By treating mental health care as an essential component of overall health maintenance, insurance systems could help normalize mental health treatment and encourage more proactive care-seeking behavior among older adults.

Data collection and outcomes measurement specific to older adult mental health care could be improved through insurance requirements and incentives. By implementing standardized assessment tools and requiring regular reporting on mental health outcomes, insurers could help identify patterns of care disparities and measure the effectiveness of different treatment approaches. This data could then inform future policy decisions and help target resources more effectively.

Crisis intervention and emergency mental health services could be enhanced through insurance coverage for specialized geriatric crisis teams and after-hours support services. This might include coverage for mobile crisis units trained in geriatric mental health, 24/7 telephone support services, and rapid-access appointments with mental health specialists during critical periods.

By implementing these comprehensive changes, insurance systems could create a more robust and accessible mental health care system for older adults. Success would require ongoing collaboration between insurers, providers, and mental health specialists, along with regular evaluation of program effectiveness and willingness to adapt approaches based on emerging needs and evidence. Through these efforts, insurance systems could help combat ageism in mental health care while ensuring that older adults receive the comprehensive, high-quality mental health services they deserve.

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

Reducing ageism in healthcare yields far-reaching societal benefits that extend well beyond individual health outcomes, creating positive ripple effects throughout the economy and social fabric. When older adults receive equitable, high-quality healthcare, they maintain better physical and mental health, enabling them to remain active participants in the workforce for longer periods. This extended workforce participation contributes valuable expertise and mentorship to younger colleagues while helping to address labor shortages in key industries. Additionally, older adults who maintain good health can continue contributing to their communities through volunteerism, civic engagement, and family support, enriching social networks and strengthening intergenerational connections.

Financial: The economic implications of reduced healthcare ageism are substantial. When age-related bias is eliminated from healthcare delivery, conditions are more likely to be diagnosed and treated early, preventing costly complications and reducing the need for extensive interventions later. This proactive approach to older adult healthcare can significantly

lower overall healthcare costs by reducing emergency department visits, decreasing hospital readmission rates, and minimizing the need for long-term care placement. The resulting cost savings can be redirected to other essential healthcare services or used to further improve the quality of care delivery.

Productivity: Workplace productivity benefits considerably from healthier older adults. When experienced workers can maintain their health and continue contributing to their professions, organizations retain valuable institutional knowledge and benefit from diverse age perspectives in their workforce. This multigenerational workplace environment fosters innovation through the combination of traditional wisdom and fresh perspectives, while also providing natural mentorship opportunities that enhance overall organizational effectiveness. Furthermore, older adults who remain professionally active tend to maintain better cognitive function and social engagement, creating a positive feedback loop that supports continued health and productivity.

Intergenerational: Intergenerational health improvements emerge as another significant benefit of reducing healthcare ageism. When older adults receive appropriate healthcare and maintain better health, they can more actively participate in their grandchildren's lives, sharing health-positive behaviors and attitudes across generations. This interaction helps younger family members develop more positive attitudes toward aging while benefiting from the emotional support and life experience of their older relatives. Additionally, families experience reduced caregiver burden when older adults maintain better health, allowing for more positive and mutually beneficial intergenerational relationships.

The societal impact extends to healthcare system efficiency and effectiveness. When ageist practices are eliminated, healthcare providers develop more accurate diagnostic skills and treatment approaches that benefit patients of all ages. This improved clinical expertise leads to better health outcomes across the age spectrum while reducing the likelihood of medical errors and unnecessary interventions. Furthermore, healthcare providers who overcome ageist biases often report greater job satisfaction and improved patient relationships, contributing to better quality of care for all patients.

Community resilience is enhanced when older adults maintain better health through non-ageist healthcare practices. Healthy older adults often serve as community leaders, volunteers, and informal caregivers, contributing significantly to social capital and community stability. Their continued engagement in community activities helps break down age-related stereotypes while fostering more inclusive and supportive neighborhood environments. This increased social integration contributes to better mental health outcomes for all community members while reducing the isolation that often affects older populations.

The reduction of healthcare ageism also promotes innovation in healthcare delivery and technology. When healthcare systems recognize and value older adults as essential healthcare consumers, they are more likely to develop age-friendly technologies and services that benefit all patients. This focus on inclusive design and service delivery can lead to improvements in healthcare accessibility and effectiveness for everyone, regardless of age. Additionally, the development of age-friendly healthcare technologies often results in more intuitive and user-friendly solutions that benefit patients across all age groups.

Public health outcomes improve significantly when ageism is reduced in healthcare settings. Better health maintenance among older adults can help contain the spread of infectious diseases, reduce the burden of chronic conditions, and promote better population health overall. This improvement in public health metrics can lead to reduced healthcare costs at a societal level while contributing to increased life expectancy and quality of life for all age groups.

Financial systems also benefit from reduced healthcare ageism. When older adults maintain better health and independence, there is less strain on pension systems, healthcare programs, and social services. This financial stability can help ensure the sustainability of important social programs while potentially allowing for expanded services and support for all age groups. Additionally, healthier older adults are more likely to maintain financial independence, contributing to economic stability at both family and community levels.

Research and medical advancement benefit from reduced ageism in healthcare through more inclusive clinical trials and better understanding of age-related health conditions. When older adults are appropriately included in medical research, the resulting findings are more representative and applicable to diverse populations. This improved research base leads to better treatment protocols and more effective healthcare interventions for all age groups, advancing medical knowledge and capabilities across the healthcare spectrum.

These broad societal benefits demonstrate that reducing ageism in healthcare is not just an ethical imperative but also a practical investment in social and economic well-being. The positive impacts ripple through multiple aspects of society, creating stronger, more resilient communities and more effective healthcare systems that better serve people of all ages.

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

The rapidly aging global population presents both significant challenges and unique opportunities for addressing ageism in healthcare systems. As demographics shift toward an older population, healthcare systems face increasing pressure to adapt their service delivery models while confronting deeply embedded ageist practices. This demographic transformation creates an urgent need for systemic change while simultaneously offering unprecedented opportunities to redesign healthcare delivery in more age-inclusive ways.

One of the primary challenges lies in the growing demand for healthcare services amid limited resources. As the proportion of older adults increases, healthcare systems must manage higher patient volumes while maintaining quality care standards. This strain on resources can inadvertently reinforce ageist practices as providers struggle to balance efficiency with personalized care. However, this challenge also presents an opportunity to innovate in healthcare delivery, potentially leading to the development of more efficient, age-friendly care models that benefit patients of all ages.

Workforce development presents another significant challenge, as there is currently a shortage of healthcare providers with specialized training in geriatric care. This shortage is particularly acute in rural and underserved areas, where aging populations may have limited access to specialized healthcare services. Yet, this challenge creates an opportunity to reshape medical education and professional development programs, incorporating enhanced geriatric training across all healthcare disciplines and potentially creating new specialized roles to support aging populations.

Technology adoption and integration pose both challenges and opportunities in addressing healthcare ageism. While digital health solutions can improve care delivery and access, they must be designed and implemented with consideration for older adults' needs and capabilities. The opportunity lies in developing more inclusive, user-friendly technologies that can enhance healthcare delivery while bridging generational digital divides. This focus on accessible design often results in improvements that benefit all users, regardless of age.

Financial sustainability represents a significant challenge as healthcare systems adapt to serve aging populations. The increased prevalence of chronic conditions and complex health needs among older adults can strain healthcare budgets and resources. However, this challenge creates opportunities to develop innovative payment models and care delivery systems that emphasize prevention, early intervention, and coordinated care, potentially reducing long-term costs while improving outcomes.

Cultural transformation within healthcare organizations presents another crucial challenge. Deeply ingrained ageist attitudes and practices can be difficult to change, particularly in established healthcare institutions. Yet, the increasing visibility of aging-related issues provides an opportunity to challenge these biases directly, implement new training programs, and establish more age-inclusive organizational cultures that better serve all patients.

The integration of mental health services with physical healthcare presents both challenges and opportunities. While older adults often face complex mental health needs, current healthcare systems may struggle to provide comprehensive, integrated care. This challenge offers an opportunity to develop more holistic care models that address both physical and mental health needs, potentially improving overall health outcomes while reducing stigma around mental health care for older adults.

Data collection and quality measurement present technical challenges in addressing healthcare ageism, as current systems may not adequately capture age-related disparities in care quality and outcomes. However, this challenge creates opportunities to develop more sophisticated monitoring systems and quality metrics that can better identify and address ageist practices while tracking the effectiveness of intervention strategies.

Community engagement and social support systems face challenges in adapting to serve larger aging populations, particularly in areas with limited resources. Yet, this challenge presents opportunities to develop innovative community-based programs that can support healthy aging while reducing isolation and improving access to healthcare services. These programs can strengthen social connections while providing valuable support to both older adults and their caregivers.

Research and innovation in aging-related healthcare present both challenges and opportunities. While conducting research with older adult populations can be complex, the growing focus on aging-related issues creates opportunities for groundbreaking studies that can improve our understanding of aging processes and lead to more effective interventions. This research can help challenge ageist assumptions while developing more evidence-based approaches to caring for aging populations.

Policy development and implementation face challenges in keeping pace with changing demographic needs while ensuring equitable access to healthcare services. However, these challenges create opportunities to reshape healthcare policies in ways that better support aging populations while addressing systemic ageism. This might include developing new quality standards, implementing age-friendly healthcare requirements, and creating incentives for providers to improve care for older adults.

The intersection of ageism with other forms of discrimination presents complex challenges in ensuring equitable healthcare access and outcomes. Yet, this challenge offers opportunities to develop more comprehensive approaches to addressing healthcare disparities, potentially leading to improvements in care delivery for all marginalized populations. By addressing these intersecting forms of discrimination, healthcare systems can work toward more equitable and inclusive care delivery models.

These challenges and opportunities demonstrate that addressing ageism in healthcare requires a comprehensive, multi-faceted approach that acknowledges current limitations while actively working toward innovative solutions. Success in this endeavor will require sustained commitment from healthcare providers, policymakers, and community leaders, along with ongoing evaluation and adaptation of intervention strategies to meet evolving needs.

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

Healthcare organizations can implement comprehensive programs to combat ageism while promoting dignity and autonomy through carefully designed, multi-level initiatives. At the foundational level, organizations should establish mandatory age-sensitivity training programs for all staff members, from frontline healthcare providers to administrative personnel. These training programs should focus on recognizing implicit age bias, understanding the diverse needs and capabilities of older adults, and developing communication skills that promote respect and patient autonomy. Regular refresher courses and ongoing professional development opportunities can help ensure that anti-ageist practices become deeply embedded in organizational culture.

Patient-centered care programs can be enhanced through the implementation of comprehensive geriatric assessment protocols that consider not only medical needs but also psychological, social, and functional aspects of aging. These assessments should incorporate structured opportunities for older adults to express their life histories, preferences, goals, and concerns about their care. Programs should establish clear protocols for incorporating these preferences into care planning, ensuring that older adults maintain agency in their healthcare decisions while receiving appropriate support and guidance.

Healthcare organizations can advance dignity-promoting initiatives by creating age-friendly physical environments that support independence and comfort. This includes designing spaces with adequate lighting, clear signage, comfortable seating, and appropriate acoustic properties that facilitate communication. Programs should also address the scheduling and delivery of services to accommodate the varied needs of older adults, including flexible appointment times, extended consultation periods, and transportation assistance when needed.

Mentorship and reverse mentorship programs can be particularly effective in reducing ageist attitudes while promoting intergenerational understanding. Pairing experienced older healthcare providers with younger colleagues can help transfer valuable knowledge and experience, while younger staff members can share innovative approaches and technical expertise. These relationships can help break down age-related stereotypes while fostering mutual respect and collaborative learning environments.

Technology adoption programs should focus on implementing age-inclusive digital health solutions that enhance rather than replace personal care. These initiatives should include careful assessment of older adults' technology preferences and capabilities, along with providing appropriate training and support for both patients and healthcare providers. Programs should ensure that technology solutions promote independence and engagement while maintaining essential human connections in healthcare delivery.

Community engagement programs can significantly advance anti-ageist initiatives by creating partnerships between healthcare organizations and local senior communities. These programs might include advisory boards with strong older adult representation, community health education programs led by older adults, and volunteer opportunities that leverage the

experience and expertise of senior community members. Such initiatives help ensure that healthcare services remain responsive to community needs while promoting active engagement of older adults in healthcare decision-making.

Quality improvement programs should incorporate specific metrics for measuring and addressing age-related care disparities. These initiatives should include regular assessment of patient experiences, outcomes monitoring stratified by age, and systematic review of care protocols to identify and eliminate ageist practices. Programs should establish clear accountability measures and feedback mechanisms to ensure continuous improvement in age-equitable care delivery.

Staff wellness programs can help address the emotional and psychological aspects of caring for aging populations while preventing burnout that might contribute to ageist behaviors. These initiatives should include support groups, stress management resources, and opportunities for staff to process challenging experiences and share successful strategies for providing dignified care to older adults.

Educational outreach programs can help combat ageism by providing accurate information about aging processes and challenging common misconceptions. These initiatives should include public education campaigns, healthcare provider continuing education programs, and resources for families and caregivers. Programs should emphasize the diversity of aging experiences while promoting positive examples of healthy aging and active engagement in healthcare decision-making.

Care coordination programs can be enhanced to better support older adults' autonomy and well-being through improved communication between healthcare providers, social services, and community resources. These initiatives should include clear protocols for information sharing, regular team meetings to discuss complex cases, and designated care coordinators who can help older adults navigate the healthcare system while maintaining their independence.

Research and evaluation programs should be established to measure the effectiveness of anti-ageism initiatives and identify areas for improvement. These programs should include both quantitative and qualitative assessment methods, with particular attention to gathering feedback from older adults about their care experiences. Regular evaluation results should be used to refine and enhance program initiatives while sharing successful strategies with other healthcare organizations.

Policy advocacy programs can help advance systemic changes that promote age-equitable healthcare delivery. These initiatives should include working with professional organizations, policymakers, and advocacy groups to promote age-friendly healthcare policies and practices. Programs should also focus on developing and implementing organizational policies that protect older adults' rights and promote their active participation in healthcare decisions.

Through these comprehensive program initiatives, healthcare organizations can work to create more age-inclusive environments that respect the dignity and autonomy of older adults while promoting their overall well-being. Success requires ongoing commitment, regular evaluation, and willingness to adapt programs based on emerging needs and evidence of effectiveness.

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?

The roots of healthcare ageism extend deep into social, cultural, and economic structures, creating a complex web of factors that perpetuate age-based discrimination in medical settings.

Socially, the prevalent youth-centric culture promotes negative stereotypes about aging, depicting it primarily as a period of decline and dependency rather than a natural life stage with continued potential for growth and contribution. This societal attitude infiltrates healthcare systems, influencing both provider perspectives and institutional practices. The widespread internalization of these attitudes by older adults themselves can lead to reduced healthcare-seeking behavior and lower expectations for treatment outcomes.

Cultural factors significantly shape ageist practices in healthcare through deeply embedded values and beliefs about aging. In societies that prioritize productivity and independence, older adults may be implicitly devalued when they require additional support or face health challenges. Cultural narratives that emphasize technological advancement and rapid change can further marginalize older adults, particularly in healthcare settings increasingly dependent on digital solutions. Additionally, cultural differences in how aging is viewed and respected can create disparities in healthcare delivery, especially for older adults from minority communities.

Economic pressures contribute substantially to healthcare ageism through resource allocation decisions and healthcare financing structures. The perception of older adults as economic burdens on the healthcare system can lead to implicit rationing of services and reduced investment in geriatric specialties. Healthcare reimbursement systems often undervalue the time-intensive nature of geriatric care, creating disincentives for providers to specialize in older adult care or spend adequate time with elderly patients. These economic factors can result in reduced access to specialized services and lower quality of care for older populations.

Public awareness campaigns represent a crucial strategy for addressing these contributing factors. Effective campaigns should focus on reframing aging as a natural and valuable life stage while highlighting the diverse experiences and contributions of older adults. These initiatives should utilize multiple media channels to reach different audiences, incorporating positive aging narratives, success stories, and accurate information about aging processes. Campaigns should also work to expose and challenge common ageist stereotypes while promoting intergenerational understanding and connection.

Policy reforms can address structural factors contributing to healthcare ageism through targeted legislation and regulatory changes. These reforms should focus on strengthening age discrimination protections in healthcare settings, implementing mandatory geriatric training requirements for healthcare providers, and establishing quality metrics specific to age-equitable care. Additionally, policy changes should address healthcare financing structures to better support comprehensive geriatric care and create incentives for providers to develop expertise in older adult healthcare.

Educational initiatives within healthcare systems can help address knowledge gaps and cultural biases that contribute to ageist practices. These programs should provide comprehensive training in geriatric care while incorporating cultural competency elements that address diverse aging experiences. Healthcare education should emphasize the importance of person-centered care approaches that respect individual autonomy and preferences, regardless of age.

Economic strategies to combat healthcare ageism should focus on creating financial incentives for age-friendly healthcare practices while addressing resource allocation disparities. This might include enhanced reimbursement rates for comprehensive geriatric assessments, support for age-friendly facility modifications, and funding for specialized geriatric training programs. Healthcare organizations should also invest in technology solutions that promote accessibility and inclusion for older adults.

Community engagement strategies can help address social factors contributing to ageism by creating opportunities for meaningful intergenerational interaction and dialogue. Healthcare organizations should develop partnerships with community organizations to create programs that bring together people of different ages, fostering mutual understanding and challenging age-related stereotypes. These initiatives can help build more supportive and inclusive communities while reducing social isolation among older adults.

Research initiatives play a crucial role in addressing healthcare ageism by providing evidence-based insights into effective interventions and best practices. Studies should examine the impact of various anti-ageism strategies while identifying successful approaches for promoting age-equitable care. Research should also investigate the economic benefits of reducing healthcare ageism, helping to build support for investment in age-friendly healthcare practices.

Professional development programs within healthcare organizations should focus on building cultural competency and age-sensitivity among staff members. These programs should provide ongoing training and support for healthcare providers while creating opportunities for reflection and discussion about age-related biases. Organizations should also establish mentorship programs that facilitate knowledge sharing between experienced providers and newer professionals.

Technology adaptation strategies can help address digital barriers that contribute to healthcare ageism. Healthcare organizations should invest in user-friendly systems that accommodate diverse needs and abilities while providing appropriate training and support for older adults. Technology solutions should enhance rather than replace personal interactions, ensuring that digital healthcare innovations promote inclusion rather than exclusion.

Monitoring and evaluation systems should be established to track progress in addressing healthcare ageism while identifying areas requiring additional attention. These systems should incorporate both quantitative and qualitative measures, including regular feedback from older adults about their healthcare experiences. Results should be used to refine and improve anti-ageism initiatives while sharing successful strategies across healthcare organizations.

Through these comprehensive strategies, healthcare systems can work to address the complex factors contributing to ageism while creating more inclusive and equitable care environments. Success requires sustained commitment from multiple stakeholders, including healthcare providers, policymakers, community leaders, and older adults themselves, working together to promote positive change and ensure high-quality, respectful care for all ages.

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?

Education and training play pivotal roles in addressing age-related biases within healthcare settings, serving as primary tools for transforming both individual attitudes and institutional cultures. For healthcare providers in training, comprehensive geriatric education must be integrated throughout the curriculum rather than treated as an isolated specialty. This integrated approach helps students understand aging as a natural life process while developing skills to recognize and challenge their own age-related biases. Early exposure to healthy, active older adults through community engagement programs can help counter negative stereotypes before they become ingrained, while structured interactions with older patients in clinical settings provide opportunities to develop effective communication skills and person-centered care

approaches.

For practicing healthcare providers, effective education models must acknowledge and address the time constraints and practical challenges of continuing education while providing meaningful opportunities for growth and reflection. Case-based learning sessions, which present real-world scenarios highlighting age-related bias in clinical decision-making, have proven particularly effective. These sessions allow providers to examine their own biases in a safe, supportive environment while developing practical strategies for providing more equitable care. Regular feedback sessions with older patients and their families can also provide valuable insights into the impact of age-related bias on care experiences.

Implicit bias training represents a crucial component of both initial and ongoing education programs. Using validated assessment tools like the Implicit Association Test (IAT) for age bias, providers can gain awareness of their unconscious prejudices. However, awareness alone is insufficient; effective training programs must also provide concrete strategies for mitigating the impact of these biases on clinical practice. This might include structured decision-making protocols that help providers separate age-related assumptions from evidence-based clinical indicators.

Simulation-based training offers powerful opportunities for providers to experience and understand the challenges faced by older adults in healthcare settings. Using age simulation suits, modified vision and hearing, and other experiential tools, providers can develop increased empathy and understanding of the physical and sensory changes that may affect older patients. These experiences often lead to practical improvements in care delivery and communication approaches while challenging assumptions about older adults' capabilities and needs.

Mentorship programs play a valuable role in addressing age-related bias, particularly when they include reverse mentorship components. Pairing experienced healthcare providers with younger colleagues creates opportunities for bilateral learning: senior providers can share clinical expertise and wisdom, while younger staff members can help challenge traditional assumptions and introduce innovative approaches to age-inclusive care. These relationships help break down generational barriers while promoting continuous professional development.

Cultural competency training must be integrated with age-bias education to address the intersectional nature of healthcare discrimination. Effective programs help providers understand how age-related bias can interact with other forms of discrimination, including racism, sexism, and ableism. This intersectional approach helps providers develop more nuanced understanding of diverse aging experiences while improving their ability to provide culturally sensitive, person-centered care.

Technology training represents another crucial element of age-bias education, particularly as healthcare systems become increasingly digitized. Providers need guidance in using technology in ways that enhance rather than impede care for older adults, including strategies for assessing individual capabilities and preferences. This training should emphasize the importance of maintaining meaningful human connection while leveraging technological tools to improve care delivery.

Regular assessment and feedback mechanisms must be incorporated into education programs to measure their effectiveness and guide ongoing improvement. This might include pre- and post-training evaluations of provider attitudes and behaviors, patient satisfaction surveys focused on age-related care experiences, and analysis of clinical outcomes stratified by age. These assessments help identify areas requiring additional attention while demonstrating the

value of continued investment in age-bias education.

Professional development programs should also address the emotional and psychological aspects of caring for aging populations. This includes strategies for managing complex care situations, dealing with loss and grief, and maintaining professional boundaries while providing compassionate care. Support groups and peer discussion forums can provide valuable opportunities for providers to process challenging experiences and share successful approaches to age-inclusive care.

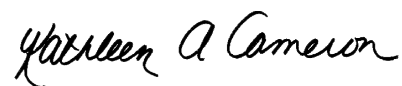
Policy-focused education helps providers understand their role in advocating for systemic changes that promote age-equitable healthcare. This includes training in identifying discriminatory policies and practices, developing evidence-based arguments for change, and effectively engaging with administrative and regulatory bodies. Such education empowers providers to become active agents in transforming healthcare systems to better serve older adults.

Quality improvement methodologies should be integrated into education programs, helping providers develop skills in identifying and addressing age-related care disparities within their practice settings. This includes training in data collection and analysis, implementation of evidence-based interventions, and evaluation of improvement efforts. These skills enable providers to contribute meaningfully to organizational efforts to reduce healthcare ageism.

Through these comprehensive educational approaches, healthcare organizations can work to transform provider attitudes and behaviors while building more age-inclusive care environments. Success requires ongoing commitment to professional development, regular evaluation of training effectiveness, and willingness to adapt educational strategies based on emerging needs and evidence. By investing in robust education and training programs, healthcare systems can work to eliminate age-related bias while improving care quality for patients of all ages.

The NCMHA would be happy to answer any questions you may have about our comments. I can be reached at cameronkath@gmail.com. Thank you.

Sincerely,



Kathleen A. Cameron

Chair

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