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**Title of Initiative:** Advancing Health Care for Older Adults From Populations That Experience Health Disparities

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**Objective:** This initiative will support innovative research to advance the science and implementation of diagnostic and clinical care guidelines, shared decision-making to enhance care planning and patient agency, and effective strategies for coordinating care for older adults from populations that experience health disparities.

**Background:** The U.S. population of adults aged 65 and older is rapidly growing and becoming more diverse, with racial and ethnic minorities comprising nearly half of the population by 2060. Yet, disparities in health and health care continue to persist, and were magnified as a result of the COVID-19 pandemic, for many older adults from populations that experience health disparities. They are more likely to report poorer physical health, mental health, and quality of life; have more coexisting health conditions and disabilities (e.g., cognitive and functional limitations); have less access to timely diagnosis and quality care; and have more hospital inpatient stays, readmissions, and multiple care transitions. Yet, critical research gaps remain for improving the prevention, detection, and treatments for many health conditions that burden older adults from populations that experience health disparities, as well as the development of novel interventions that address shared decision-making and care coordination.

Omissions in care, including delays and misdiagnoses of diseases, are often higher among older adults from populations that experience health disparities. For example, the diagnostic error rates for 6 common diseases—chronic obstructive pulmonary disease (COPD), dementia, Parkinson’s disease, heart failure, stroke, and acute myocardial infarction—are estimated to be greater than 10%, and ranged as high as 35% for COPD, 30% for dementia, and 10-50% for Parkinson’s disease.

Chronological age should not deter access to screening or effective treatments that could improve quality of life or confer a survival benefit in older adults. Yet, ageism is a cited barrier to obtaining timely screening, assessment, diagnosis, and treatment, which negatively effects the physical and mental health of older people, and can synergistically occur with other forms of discrimination (e.g., racism). For example, one in four Black and Hispanic/Latino older adults reported that they experienced mistreatment or did not have their health concerns taken seriously by a clinician because of their race and ethnicity and as a result did not receive the care that they needed.

Recently, the National Academies of Sciences, Engineering, and Medicine workshop on Advancing Diagnostic Excellence for Older Adults (July 2022) highlighted the need for research to improve equity in diagnosis and identify strategies/interventions that can mitigate disparities in older adults. However, making a correct and timely diagnosis and care plan is a process influenced by a myriad of factors that can impair diagnostic performance and accuracy. These include intrinsic factors of the screening or diagnostic tests (e.g., sensitivity and specificity), protocols, or guidelines; presentation of symptoms that are different from traditional diagnostic patterns developed from younger populations; complexities of multiple chronic conditions and disabilities; side effects from multiple medications; or delayed recognition by patients and caregivers/family members attributing symptoms as part of the normal aging process. Extrinsic factors include underrepresentation of older adults from populations that experience health disparities in research studies that inform the development of diagnostic tests and treatments, lack of access to quality health care and specialty care (e.g., geriatrics and neurology specialists, cardiovascular specialists in older adults), limited health system resources and infrastructure, poor clinical teamwork functioning, lack of shared decision-making or decision aids, and compounding social factors (e.g., employment, isolation, housing). Additionally, shared decision-making between clinicians/care team with the older adult and their caregiver(s) should be guided by principles of self-determination and autonomy while considering preferences, harms, and benefits of diagnostic and clinical care; patient agency; and the legal aspects and cultural norms of decision-making.

Care coordination within and across care teams and care settings is a modifiable area for intervention that can mitigate health disparities in older adults. For example, care transition from one care setting or level to another is a risk factor for delayed or missed diagnoses and treatments due to the fragmentation of care between care settings and breakdowns in coordination, communication, and collaboration processes between care team members, including the older adult and caregiver. Transitional care interventions are associated with reductions in hospital and emergency room readmissions; however, interventions are sparse in care facilities, palliative or end-of-life care settings, and for populations that experience health disparities. The need for such interventions is critical, given that Black Medicare beneficiaries (39.2%) experienced significantly more care transitions (4 or more) in the last 6 months of life, while Hispanic (28.8%) and Asian (33.0%) Medicare beneficiaries were more likely to have no care transitions at the end-of-life. An absence of care transitions may indicate that family members have assumed the extra burden of caregiving because formal care outside of the home may be seen as “unnatural, disheartening, disrespectful, and insensitive.” However, many family caregivers are not trained to properly handle the stressful demands of providing and coordinating care for their loved ones. Stress from caregiving along with other competing demands and financial hardships are associated with elder mistreatment, which includes physical, psychological/verbal, and sexual abuse, neglect, and financial exploitation. Elder mistreatment is estimated to affect approximately 10% of older adults, which is likely underreported since studies relied on self-reported information and excluded participants with dementia. Some evidence suggests that older adults who identify as Black are more likely to experience financial exploitation.

Overall, research is limited on the risk and protective factors associated with elder mistreatment among older adult populations that experience health disparities, as well as strategies or interventions that address elder mistreatment and care coordination challenges across care teams, care settings, and agencies (e.g., protective services, home health, financial, legal services, housing) to improve the health and well-being of older adults from populations that experience health disparities.

**Description of Initiative:** This initiative seeks to stimulate research that addresses health disparities and health care inequities while optimizing the health and well-being of older adults from populations that experience health disparities in the U.S. and U.S. territories. For the purpose of this concept, age 65 years and older is considered the chronologic definition of an older adult. This initiative will support interventions (especially multicomponent, multisectoral, and/or multilevel interventions), clinical trials (including cluster-randomized trials and pragmatic trials), quasi-experimental studies, natural experiments (e.g., impact of policy), quality improvement studies, mixed methods research, and simulation modeling. When appropriate, studies should also meaningfully engage with older adults and their caregivers in research that is guided by principles of self-determination and autonomy.

**Research Priorities:** Areas of interest include but are not limited to:

- Addressing gaps in timely assessment, prevention, diagnosis, and treatment of coexisting disease conditions that are prevalent in older adults from populations that experience health disparities. This may include establishing or modifying diagnostic criteria or identifying phenotypes that may be different in older adults from populations that experience health disparities; developing assessment tools to assess symptom burden, quality of life, and/or function; or implementing diagnostic/care guidelines that are adaptable to different care settings and populations. Screening tests or assessments should consider tradeoffs of harm (e.g., false-positives, overdiagnosis) and benefits (e.g., quality of life), as well as optimal time for screening (e.g., intervals, stopping age).
- Addressing shared decision-making between clinicians/care team with the older adult and their caregiver(s) to enhance communication, care planning, and/or tools to improve decision-making. This may include addressing conflicting recommendations for care as well as balancing clinician, patient, and caregiver preferences regarding harms, benefits, and outcomes (e.g., quality of life, well-being, clinical outcome) while considering patient agency and the legal aspects and cultural norms of decision-making (e.g., advance directives).
- Addressing care coordination challenges or breakdowns in the diagnostic or care pathways from one care setting or level to another; multiple care transitions to and from the home, care facilities, palliative care, and end-of-life care settings; and coordinating with other agencies to meet the whole-person needs of older adults. This may include addressing care team functioning (e.g., communication) and care setting infrastructures (e.g., coordination tools) to optimize care delivery both within and across care teams

(including the patient and caregiver/family), care settings, and other agencies involved in meeting the needs of older adults.

- Preparing the care setting, including the workforce, to care for older adults while being responsive to their diverse ethnic, cultural, religious, social, economic, and geographical backgrounds. This may include the assessment of competencies for formal and informal caregivers that are better aligned and tailored to the patient's needs and values to enhance their quality of life and care delivery.
- Developing and assessing interventions in the health care settings that mitigate ageism, racism, and/or other forms of discrimination, prejudices, and stereotypes against older adults.
- Evaluating the effectiveness of existing protocols within health care settings to prevent, recognize, and address mistreatment and exploitation of older adults from populations that experience health disparities.
- Identifying and/or addressing policies that drive health care disparities in older adults (e.g., affordable care, expanded coverage, drug pricing, health care accessibility and financing).