change and will not be modified to remove personal or business information including confidential, contact, or other identifying information. Comments should not include any information such as confidential information that would not be appropriate for public disclosure.

Comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors, Ann E. Misback, Secretary of the Board, 20th Street and Constitution Avenue NW, Washington, DC 20551–0001, not later than January 13, 2025.

A. Federal Reserve Bank of Chicago (Colette A. Fried, Assistant Vice President) 230 South LaSalle Street, Chicago, Illinois 60690–1414. Comments can also be sent electronically to *Comments.applications@chi.frb.org:*

1. *Robert M. Kahn and Kristin Kahn, both of Newton, Iowa; Michael S. Albright and Mollie Albright, both of Sioux City, Iowa; and Megan Kahn, Basalt, Colorado;* to join the Kahn Family Control Group, a group acting in concert, to retain voting shares of United Iowa Bancshares Inc., and thereby indirectly retain voting shares of FNNB Bank, both of Newton, Iowa.

Board of Governors of the Federal Reserve System.

Michele Taylor Fennell,

Associate Secretary of the Board.

[FR Doc. 2024–31073 Filed 12–26–24; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Request for Information Regarding the Impact of Ageism in Healthcare

AGENCY: Agency for Healthcare Research and Quality, Department of Health and Human Services.

ACTION: Notice of request for information about the impact of ageism in healthcare and methods and strategies to address ageism in healthcare delivery.

SUMMARY: The Agency for Healthcare Research and Quality (AHRQ) is seeking information from the public to understand the impacts of ageism on healthcare quality, including aspects related to safety, timeliness, patient-centeredness, equitable distribution, and care outcomes. How does the effect of ageism differ across different population groups? We are interested in identifying efforts and innovative strategies and programs that address and mitigate ageism to optimize older adults' health.

DATES: Comments must be submitted on or before March 15, 2025. AHRQ will not respond individually to responders but will consider all comments submitted by the deadline.

ADDRESSES: Submissions should follow the Submission Instructions below. We prefer that information be submitted electronically on the submission website. Email submissions may also be sent to *ecareplan@ahrq.hhs.gov.*

FOR FURTHER INFORMATION CONTACT: Jose Plascencia Jimenez, *Jose.Plascenciajimenez@ahrq.hhs.gov.* Telephone 301–427–1364.

SUPPLEMENTARY INFORMATION: The Agency for Healthcare Research and Quality (AHRQ) is seeking information from the public to understand the effects of ageism on healthcare services and outcomes. Notably, the AHRQ seeks any evidence, insights, or perspectives on the impact of ageism on care delivery and quality to identify barriers and explore opportunities to address age-related biases. Responses will inform future research priorities and studies, policies, and initiatives to improve the quality and outcomes of care for older adults.

For this RFI, ageism is defined as stereotypes, prejudice, and discrimination directed towards other people or oneself based on age.[1] While ageism is often subtle, it is woven into our workforce, healthcare systems, and everyday interactions. Ageism undermines older adults and their contributions to our communities.

Research shows that 81 percent of adults aged 50–80 report experiencing internal ageism, 65 percent are exposed to ageist messages, and 45 percent face ageism in interpersonal interactions.[2]

These statistics demonstrate how ingrained ageism is in our society. Ageism within healthcare leads to poorer health outcomes, avoidable morbidity, and costly preventable adverse events.[3]

Ageism costs our nation an estimated $63 billion annually in healthcare expenditures.[4] In health care, ageism is expressed in our social and organizational policies, the practices of clinicians, and negative assumptions held by older adults themselves. At the macro level, ageism is complex and reflected in healthcare access issues, which result in older adults being less likely to receive care consistent with medical guidelines, payment policies that do not adequately reimburse for complex care needed for older adults, and exclusion or underrepresentation of older adults in clinical trials and other research. At the micro level, practices such as the use of ageist language and elder speak, exclusion of older patients from care plan conversations, and variations in treatment practices due to a patient's age all affect patients' quality of care. Self-directed ageism can also lead to adverse outcomes for a patient if their beliefs on aging lead them to believe that the symptoms they are experiencing should be considered a ''normal'' part of aging. For example, while some cognitive decline is expected as we age, memory loss, confusion, changes in behavior, and inability to complete activities of daily living are all signs of changes in cognitive ability that need to be evaluated by a medical professional. Moreover, people who internalize ageist societal messages tend to have poorer physical, cognitive, and mental health. The reverse is also true—individuals who internalize positive aging messages are likely to exhibit benefits in physical, cognitive, and mental health—highlighting the need to promote age inclusivity.

AHRQ recognizes that due to population aging, the impact of ageism on the health and well-being of older Americans, their families, caregivers, and communities will continue to grow. Between 2009 and 2019, the number of people in the US aged 65 years and older increased 36%, from 39.6 to 54.1 million, and is projected to reach 94.7 million people in 2060. Addressing ageism is critical as the population ages, placing growing demands on healthcare systems and highlighting the need for policies that ensure compassionate and high-quality care for older adults.

Ageism does not affect all populations equally. Some groups of older adults may face additional barriers to care. Older adults living in rural or socioeconomically disadvantaged areas, those who have low incomes, or from certain racial or ethnic minority groups can face additional barriers to care, have limited access to resources, confront cultural biases, or encounter differential health services delivery. People living with disabilities may have specific needs often forgotten or neglected as they age. Women, with a higher life expectancy than men, have higher rates of chronic illnesses and functional impairments with fewer financial resources available. Understanding the compounded impact of ageism across different groups is critical to creating comprehensive strategies that ensure equitable and inclusive care that promotes healthy aging. Mitigating or eliminating the biases that encompass

ageism can potentially improve health and functional status, reduce costs, and foster intergenerational collaboration among older adults. By eliminating age-related biases, older adults may be more likely to receive timely and effective care, improving health outcomes, including functional status, and physical and mental well-being, while increasing the value of healthcare.

AHRQ encourages stakeholders to contribute their expertise and experiences to inform innovative approaches to reduce ageism in the healthcare system.

Who Should Respond

- Clinicians and other health care personnel (including community health workers, peer support personnel, system navigators, and patient advocates) who provide services to older adults and others at risk for encountering ageism, including personnel from across all care settings (primary care, specialty care, mental and behavioral health, post-acute e care, rehabilitative care, and home and community-based services).
- Researchers and implementers studying ageism or developing interventions to implement person-centered care planning in practice.
- Clinical professional societies.
- Payers.
- Healthcare delivery organizations.
- People who have experiences ageism in health care, their families, and caregivers.
- Patient advocacy groups and organizations.
- Clinical decision support developers.
- Quality and other measure developers.
- Representatives from human service agencies and/or community organizations with interest or experience in addressing ageism.
- Higher education institutions that train clinicians and healthcare personnel and/or train those involved in community health and education.
- Clinical and public health decision-makers.
- Health technology developers focused on improving health outcomes among older adults.

Specific questions of interest to the AHRQ include, but are not limited to, the following:

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

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

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?

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

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?

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

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

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

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

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

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

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

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?

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?

AHRQ is interested in all the questions listed above. Still, respondents are welcome to address as many or as few as they choose and to address additional areas of interest regarding ageism not listed. It is helpful to identify the question to which a particular answer corresponds.

This RFI is for planning purposes only and should not be construed as a policy, solicitation for applications, or as an obligation on the part of the Government to provide support for any ideas in response to it. AHRQ will use the information submitted in response to this RFI at its discretion and will not comment on any respondent's submission. However, responses to this RFI may be reflected in future solicitation(s) or policies. The information provided will be analyzed and may appear in reports. Respondents will not be identified in any published reports. Respondents are advised that the Government is not obligated to acknowledge receipt of the information received or provide feedback to respondents concerning any information submitted. No proprietary, classified, confidential, or sensitive information should be included in your response. The contents of all submissions will be made available to the public upon request. Submitted materials must be publicly available or able to be made public.

(Authority: Section 902 of the Public Health Service Act, 42 U.S.C. 299a.)

Dated: December 20, 2024.

Marquita Cullom,

Associate Director.

Footnotes

1. World Health Organization. Global Report on Ageism. Geneva: World Health Organization; 2021. Global report on ageism (who.int). Accessed July 20, 2022.

2. Allen JO, Solway E, Kirch M, Singer D, Kullgren J, Moise V, Malani P. Experiences of Everyday Ageism and the Health of Older US Adults JAMA Open Network. 2022; 15 (5): e2217240.

3. Allen JO. Ageism as a risk factor for chronic disease. Gerontologist. 2016;56(4);610–614. Doi:10.1093/geront/gnw118.

4. Levy BR, Slade MD, Chang ES, Kannoth S, Wang SY. Ageism amplified cost and prevalence of health conditions. Gerontologist. 2020;60(1): 174–181. doi:10.1093/geront/gny131.

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