continuing the success of these programs. The current Alliant GWACs for Information Technology services are among GSA's most successful acquisition programs for the federal government with 50 federal agencies doing more than $20 billion in business volume since their inception in 2009. GSA Alliant and Alliant Small Business GWACs are used for complex IT requirements involving data center consolidation, systems integration, cloud computing, cyber security, help desk support, and other IT disciplines.

The Alliant II and Alliant Small Business II Interact communities will serve as the one-stop-shop for updates and information regarding the next-generation Alliant GWACs. The scope of the Alliant GWACs is built on the foundation of Federal Enterprise Architecture allowing for in-scope acquisition of new and emerging technologies. The GSA GWAC Program is widely acclaimed for superior customer service, scope reviews, and acquisition support.

Dated: April 2, 2014.

Christopher Fornecker,

Director, Center for GWAC Programs, Office of Strategic Programs, Integrated Technology Service.

[FR Doc. 2014–07794 Filed 4–7–14; 8:45 am]

BILLING CODE 6820–XX–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Advisory Council on Alzheimer's Research, Care, and Services; Meeting

AGENCY: Assistant Secretary for Planning and Evaluation, HHS.

ACTION: Notice of meeting.

SUMMARY: This notice announces the public meeting of the Advisory Council on Alzheimer's Research, Care, and Services (Advisory Council). The Advisory Council on Alzheimer's Research, Care, and Services provides advice on how to prevent or reduce the burden of Alzheimer's disease and related dementias on people with the disease and their caregivers. During the April meeting, the Advisory Council will hear presentations from the three subcommittees (Research, Clinical Care, and Long-Term Services and Supports). The Advisory Council will hear updates to the 2014 plan. The Advisory Council will also hear presentations on state and local plans to address dementia.

DATES: The meeting will be held on April 29th, 2014 from 9:00 a.m. to 5:00 p.m. EDT.

ADDRESSES: The meeting will be held in Room 800 in the Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

Comments: Time is allocated mid-morning on the agenda to hear public comments. In lieu of oral comments, formal written comments may be submitted for the record to Rohini Khillan, OASPE, 200 Independence Avenue SW., Room 424E, Washington, DC 20201. Comments may also be sent to *napa@hhs.gov.* Those submitting written comments should identify themselves and any relevant organizational affiliations.

FOR FURTHER INFORMATION CONTACT: Rohini Khillan (202) 690–5932, *rohini.khillan@hhs.gov.* **Note:** Seating may be limited. Those wishing to attend the meeting must send an email to *napa@hhs.gov* and put ''April 29 meeting attendance'' in the Subject line by Friday, April 18, so that their names may be put on a list of expected attendees and forwarded to the security officers at the Department of Health and Human Services. Any interested member of the public who is a non-U.S. citizen should include this information at the time of registration to ensure that the appropriate security procedure to gain entry to the building is carried out. Although the meeting is open to the public, procedures governing security and the entrance to Federal buildings may change without notice. If you wish to make a public comment, you must note that within your email.

SUPPLEMENTARY INFORMATION: Notice of these meetings is given under the Federal Advisory Committee Act (5 U.S.C. App. 2, section 10(a)(1) and (a)(2)). Topics of the Meeting: The Advisory Council will hear presentations from the three subcommittees (Research, Clinical Care, and Long-Term Services and Supports), which will inform the 2014 recommendations. The Advisory Council will discuss the G8 Dementia Summit that was held on December 11, 2013.

Procedure and Agenda: This meeting is open to the public. Please allow 30 minutes to go through security and walk to the meeting room. The meeting will also be webcast at *www.hhs.gov/live.*

Authority: 42 U.S.C. 11225; Section 2(e)(3) of the National Alzheimer's Project Act. The panel is governed by provisions of Public Law 92–463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees.

Dated: March 24, 2014.

Rima Cohen,

Acting Assistant Secretary for Planning and Evaluation.

[FR Doc. 2014–07596 Filed 4–7–14; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Agency for Healthcare Research and Quality, HHS.

ACTION: Notice.

SUMMARY: This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed information collection project: ''*Taking Efficiency Interventions in Health Services Delivery to Scale.*'' In accordance with the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)), AHRQ invites the public to comment on this proposed information collection.

DATES: Comments on this notice must be received by June 9, 2014.

ADDRESSES: Written comments should be submitted to: Doris Lefkowitz, Reports Clearance Officer, AHRQ, by email at *doris.lefkowitz@ahrq.hhs.gov.*

Copies of the proposed collection plans, data collection instruments, and specific details on the estimated burden can be obtained from the AHRQ Reports Clearance Officer.

FOR FURTHER INFORMATION CONTACT: Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427–1477, or by email at *doris.lefkowitz@ahrq.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Proposed Project

Taking Efficiency Interventions in Health Services Delivery to Scale

The primary care workforce is facing imminent clinician shortages and increased demand. With the implementation of the Affordable Care Act (ACA), Federally Qualified Health Centers (FQHCs) are expected to play a major role in addressing the large numbers of people who become eligible for health insurance as well as continue in their role as safety net providers. Thus, understanding new models of service delivery and improving efficiency within FQHCs is of national policy import. The proposed data collection supports this goal through studying outcomes associated with a ''delegate model,'' which is designed to improve provider and team efficiency, and the spread of this model throughout a large FQHC.

Recent models of practice transformation have documented the

use of an Organized Team Model that distributes responsibility for patient care among an interdisciplinary team, thus allowing physicians to manage a larger panel size while practicing high quality care. This delegate model requires that all team members perform at the top of their skill level, and that tasks currently performed by clinicians are delegated to non-clinician team members in a safe and effective manner. Researchers at the University of California, San Francisco have estimated that delegation may allow physicians to increase their panel size by shifting tasks to non-physician team members. More specifically, if portions of preventive and chronic care services are delegated to non-physicians, primary care practices can meet recommended quality and care guidelines while maintaining panel sizes with a limited primary care physician workforce. This study will examine the real-world implementation of such a model in order to build evidence of whether such delegation can achieve the predicted increases in panel sizes.

AHRQ is working with John Snow, Inc. (JSI) and its partner, Penobscot Community Health Center (PCHC), to evaluate the effectiveness and spread of a delegate model in 5 of PCHC's 15 primary care service sites. The model will be spread from an initial pilot physician-medical assistant team to other clinics, as well as to other teams within each clinic. PCHC is an FQHC located in Bangor, Maine that serves northeastern Maine. Currently, PCHC's primary care providers (PCPs, which include medical doctors, osteopaths, nurse practitioners, and physician assistants) each work with a Medical Assistant (MA). Under the delegate model, a pair of PCPs will be assigned an ''administrative'' MA to enhance their team. This position will enable shifting of responsibilities among the team, with the intent of relieving the PCPs of administrative tasks and incorporating new tasks that will enhance team efficiency. Examples of tasks that an administrative MA may take on include standardized prescription renewals, schedule management, in-box management, scribing, pre-visit planning with pre-appointment laboratory tests, and identification of patients for ancillary referrals (e.g., behavioral health and case management).

This study has the following goals:

(1) To evaluate the spread and effectiveness of the delegate model in five of PCHC's primary care sites;

(2) To evaluate the influence of the delegate model on provider satisfaction, team functioning, and patient satisfaction;

(3) To assess the contextual factors influencing the above outcomes; and

(4) To disseminate findings.

This study is being conducted by AHRQ through its contractor, JSI, pursuant to AHRQ's statutory authority to conduct and support research on healthcare and on systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness and value of healthcare services and with respect to quality measurement and improvement. 42 U.S.C. 299a(a)(1) and (2).

Method of Collection

AHRQ seeks approval for the following data collection activities:

- Team Survey that will be disseminated to all members of both delegate and non-delegate primary care teams to assess job satisfaction and team functioning in all participating sites at two points in time.
- Key Informant Interviews (KII) conducted with staff in each of the participating sites during two rounds of site visits, with key informants to include the Medical Director, Practice Director, members of primary care teams implementing the delegate model, and ancillary staff. A condensed version of the interview will be used for a conference call with each participating site's Medical Director and Practice Director as an interim activity between the two site visits.

The information yielded from this study is expected to inform a wide cross section of audiences and stakeholders about provider efficiency, practice redesign, team-based care, workforce strategies, and spread of an innovation. This study is not intended to make broad generalizations about the effectiveness of the delegate model of care, but rather to build initial evidence about this promising new model, its ability to increase panel size in FQHCs, and provide guidance on how similar models might be spread and evaluated.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden for the respondents' time to participate in this research. Information will be collected through an internet-based team survey and in-person and telephone interviews. Note that some respondents may be double-counted, so the total number of respondents may be less than 80. For example, a respondent may fill out a survey as well as participate in a phone interview.

Exhibit 2 shows the estimated annualized cost burden associated with the respondents' time to participate in this research. The total annual cost burden is estimated to be $25,151.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Team Survey:				
—Providers	21	2	15/60	11
—Other Clinical Staff	34	2	15/60	17
Total	55	2	15/60	28
Key Informant Interviews (Site visits):				
—Medical Director	2	2	30/60	2
—Practice Director	2	2	30/60	2
—Providers	5	2	30/60	5
—Other Clinical Staff	10	2	30/60	10
Total	19	2	30/60	19
Key Informant Interviews (Phone calls):				
—Medical Director	3	1	1	3

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS—Continued

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
—Practice Director	3	1	1	3
Total	6	1	1	6
Total	80	na	na	53

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate*	Total cost burden
Team Survey:				
—Providers	21	11	[a] $62.13	$14,352
—Other Clinical Staff	34	17	[b] 14.69	8,491
Total	55	28	na	22,843
Key Informant Interviews (Site Visit):				
—Medical Director	2	2	[c] 92.08	368
—Practice Director	2	2	[d] 47.34	189
—Providers	5	2	[a] 62.13	621
—Other Clinical Staff	10	2	[b] 14.69	294
Total	19	8	na	1,472
Key Informant Interviews (Phone calls):				
—Medical Director	3	2	[c] 92.08	552
—Practice Director	3	2	[d] 47.34	284
Total	6	4	na	836
Total	80	na	na	25,151

* National Compensation Survey: Occupational wages in the United States May 2012, "U.S. Department of Labor, Bureau of Labor Statistics."
[a] Based on the average mean wages for three categories of primary care provider ($92.08—MDs; $44.45 PAs; and $43.97—NPs).
[b] Based on the mean wage of Medical Assistants.
[c] Based on the mean wages for MDs.
[d] Based on the mean wages for Medical and Health Services Managers.
[e] Based on the mean wages for Data Analyst (Computer and Information Analyst).

Request for Comments

In accordance with the Paperwork Reduction Act, comments on AHRQ's information collection are requested with regard to any of the following: (a) Whether the proposed collection of information is necessary for the proper performance of AHRQ health care research and health care information dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ's estimate of burden (including hours and costs) of the proposed collection(s) of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information upon the respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: March 31, 2014.

Richard Kronick,

AHRQ Director.

[FR Doc. 2014–07795 Filed 4–7–14; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Meeting for Software Developers on the Common Formats for Patient Safety Data Collection and Event Reporting—Agenda & Registration Information

In reference to **Federal Register**, Vol. 79, No. 15, pages 3815–3816, published on January 23, 2014 (*https://www.federalregister.gov/articles/2014/01/23/2014-01242/meeting-for-software-developers-on-the-common-formats-for-patient-safety-data-collection-and-event*), AHRQ is now providing additional information on the Software Developers Meeting—AHRQ Common Formats meeting agenda and registration.

As indicated in the previous notice, the PSO Privacy Protection Center (PSOPPC) is coordinating the meeting. On Friday, April 25, 2014, the meeting will start at 10:00 a.m. with welcome and updates on data submissions issues. After a networking lunch, a keynote presentation will focus on electronic health record (EHR) technology, patient safety, and federal regulation. Finally, the meeting will conclude with presentations on and discussion of federal initiatives involving the Common Formats. Throughout the meeting there will be interactive discussion to allow meeting participants not only to provide input, but also to respond to the input provided by others. Meeting information, including the full