and implementation of the agency's strategic plan that establishes long and short-range goals, objectives, strategies and action plans for advancing the agency's policy and program agenda. Reviews and coordinates all policy and program development documents, regulations and activities to ensure consistency with ACL's strategic plan; and adjusts goals and strategies as appropriate. Coordinates the identification and analysis of emerging policy issues and trends and appropriate Federal responses. Formulates an agency-wide policy and program development strategy consistent with the priorities established by the Administrator and the Principal Deputy Administrator.

Plans and directs the evaluation of ACL programs designed to provide planning, coordination and services to older Americans and people with disabilities. The Director serves as the Performance Improvement Officer and is the primary liaison with the Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Office of the Assistant Secretary for Financial Resources (ASFR), and the Office of Management and Budget (OMB) for program performance and evaluation activities.

2. Office of Policy Analysis and Development (BFB). The Office of Policy Analysis and Development (OPAD) analyzes trends in demographics, service needs, public policies and program development, and translates those trends into new policies and initiatives in long-term services and supports and health care that assist people with disabilities and older individuals to remain in their own homes and communities.

Directs intergovernmental activities as they relate to the agency's policy and program development agenda, and develops and maintains effective relationships with other governmental departments and agencies. Plans, negotiates, facilitates and updates, as appropriate, memoranda of understanding with other departments and agencies to promote agreements and cooperative relationships. Maintains information on, and pursues collaborative opportunities with, other Federal agencies, non-profit organizations and private corporations that have the potential to contribute to the agency's policy and program development priorities.

Provides technical, program and policy development input on legislative activities and the annual budget. Participates in Departmental and inter-departmental activities that concern health and long-term care; reviews and comments on Departmental regulations and policies regarding health programs, institutional and non-institutional long-term care services, and those designed to enhance community living.

Conducts relevant policy research, carries out periodic reviews of needs and resources in the fields of aging and disability, and undertakes qualitative and quantitative analyses to develop policy options and recommendations for the Administrator and the Principal Deputy Administrator. Develops policy reports based on the needs and circumstances of older people, their family members and the aging population. Develops and coordinates initiatives with other Federal agencies, national aging organizations, national disability organizations, and universities to fill gaps in information in the field of aging and disability.

3. Office of Performance and Evaluation (BDC). The Office of Performance and Evaluation (OPE), in collaboration with the respective ACL program offices, implements, oversees and manages ACL's program performance responsibilities, data collection systems, and program evaluation activities. Develops plans and priorities for evaluation of ACL programs, with subject matter input from appropriate units. Manages contracts for mandated evaluation projects and performs intramural evaluation studies. Prepares reports of the results of program and impact evaluations conducted by and for ACL, with technical input from other ACL units. Provides technical guidance on evaluation activities conducted as part of ACL's discretionary grants programs.

Implements the requirements of the Government Performance and Results Act of 1993 (GPRA) and the GPRA Modernization Act of 2010. Interprets ACL goals, priorities, and strategies for consistency with ACL long-range GPRA goals and strategies, and adjusts GPRA goals and strategies accordingly. Provides guidance and technical assistance to ACL organizational units in developing operational plans, particularly in developing measurable objectives and indicators reflecting program and organizational performance. Prepares annual GPRA plans and reports and coordinates with the Office of Budget and Finance on the development of the ACL performance budget.

Coordinates ACL activities related to the collection, analysis, and dissemination of national and program data on older individuals and individuals with disabilities. Develops and manages data requirements; designs the criteria for collecting, analyzing and disseminating program performance data; and prepares the data for reporting to Congress and the public. Designs, implements and provides guidance and technical assistance to funding recipients on data collection and analysis. Works with the Office of Information Resources Management to coordinate mandated Office of Management and Budget (OMB) approvals required under the Paperwork Reduction Act of 1980, as amended.

Compiles, publishes, and disseminates information on demographic data and data from other Federal agencies on the health, social and economic status of older persons and persons with disabilities. Performs routine and special statistical analyses of data for ACL offices, other Federal and non-Federal organizations, and the general public.

II. Delegations of Authority: All delegations and re-delegations of authority made to officials and employees of affected organizational components will continue in them or their successors pending further re-delegations.

III. Funds, Personnel and Equipment: Transfer of organizations and functions affected by this reorganization shall be accompanied in each instance by direct and support funds, positions, personnel, records, equipment, supplies and other resources.

Dated: August 29, 2014.

Sylvia M. Burwell,

Secretary.

[FR Doc. 2014–24639 Filed 10–15–14; 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: ''Care Coordination Quality Measure for Patients in the Primary Care Setting.'' In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3521, AHRQ invites the public to comment on this proposed information collection.

This proposed information collection was previously published in the **Federal Register** on July 30th, 2014 and allowed 60 days for public comment. AHRQ received and responded to comments from two members of the public. The purpose of this notice is to allow an additional 30 days for public comment.

DATES: Comments on this notice must be received by November 17, 2014.

ADDRESSES: Written comments should be submitted to: AHRQ's OMB Desk Officer by fax at (202) 395–6974 (attention: AHRQ's desk officer) or by email at *OIRA_submission@omb.eop.gov* (attention: AHRQ's desk 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

Care Coordination Quality Measure for Patients in the Primary Care Setting

Proposed Project

''Care Coordination Measure Development—Phase III''

This project is Task Order #11 under the Agency for Healthcare Research and Quality (AHRQ) Prevention and Care Management Technical Assistance Center Indefinite Delivery Indefinite Quantity contract. The project, entitled ''Care Coordination Measure Development—Phase III'', will develop a patient survey of the quality of care coordination for adults in primary care settings, i.e., the Care Coordination Quality. Measure for Primary Care (CCQM–PC). The project will update the Care Coordination Measures Atlas (*http://www.ahrq.gov/professionals/systems/long-termcare/resources/coordination/atlas/index.html*). In combination with primary research, the project will use the Atlas and prior work that identified gaps in the measurement of care coordination to develop and pilot test a rigorous and psychometrically sound patient assessment (from the perspective of patient and family) of the quality of care coordination for adults within primary care settings—the CCQM–PC. The survey will address key care coordination domains; be appropriate for research; will set the stage for the future development of measures for quality reporting, accountability, and payment purposes; and be consistent with Consumer Assessment of Healthcare Providers and Systems (CAMPS) 0 principles. The instrument is to be developed, cognitively tested, revised and pilot tested. A stakeholder panel will provide input throughout the phases of the project.

There are five explicit objectives for our analysis of the pilot-test data:

- Evaluate the quality of the responses to the CCQM–PC survey (through item functioning analysis).
- Determine how the items that ask for reports of patient experiences could be summarized into a smaller set of composite measures (through factor analysis).
- Evaluate the measurement properties of the composite scales (assessment of reliability, validity, and variability of the measure).
- Identify information (i.e., case mix adjusters) that should be used to adjust scores to ensure valid comparisons among primary care practices (PCPs).
- Determine how CCQM–PC scores vary among practices that self-report processes of care that are more or less aligned with a medical home model.

This study is being conducted by AHRQ through its contractor, American Institutes for Research (AIR), 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 quality measurement and improvement. 42 U.S.C. 299a(a)(1) and (2).

Method of Collection

Thirty primary care practices of different types and ownership configurations will be recruited to provide a patient sample to AIR for the purpose of establishing the psychometrics of the CCQM–PC and understanding the relation of its domains to a practice-level measure of processes of care, the Medical Home Index (Long Version, MHI–LV). The CCQM–PC will be conducted by mail with phone follow-up for nonrespondents. Survey operations for the CCQM–PC will follow standard CAHPS practice:

- Mail the questionnaire package, including a personalized letter introducing the study and explaining the respondent's rights as a research participant. Include a postage-paid envelope to encourage participation.
- Send a postcard reminder to nonrespondents 10 days after sending the questionnaire.
- Send a second questionnaire with a reminder letter to those who have still not responded thirty days after the first mailing.
- Begin follow-up by telephone with nonrespondents three weeks after sending the second questionnaire. Interviewers will attempt to locate respondents who have not responded to the mailed survey.
- Verify telephone numbers for sample respondents prior to calling.
- Make a maximum of 9 attempts by phone.
- Include a toll-free number in the cards and letters for respondents to call if they have questions about the survey. The firm responsible for fielding the survey will establish a helpdesk that will start operating at the first mailing and that will remain open until close of fieldwork.
- Answer incoming calls live during business hours and a recording machine will capture after hours calls. The after-hours calls will be returned next business day.
- Ask two clinicians from each participating practice complete the MHI–LV by paper-and-pencil jointly and return the form to the AHRQ contractor.

The information collected in the pilot survey will be used to test and improve the draft survey. The pilot design will support the standard suite of psychometric analyses conducted to identify and develop composite scoring algorithms as well as to provide evidence of the reliability and construct validity of the composite scores and any scores based on individual items. Additionally, the variations in composite scores and total CCQM–PC scores will be examined for any differences that may be correlated with variations in the practice's self-assessment of its engagement in processes of care that are consistent with the medical home model. The analyses will include the following components:

- Item functioning analysis
- Confirmatory Factor Analysis
- Exploratory Factor Analysis
- Evaluation of the reliability, validity, and variability of composite and single-item scores
- Case mix adjustment (if the data indicate this is needed).

Because the survey items are being developed to measure specific aspects of care coordination in accordance with the domain framework developed through previous phases of AHRQ's Care Coordination Measure Development portfolio, the factor structure of the survey items will be evaluated through multilevel confirmatory factor analysis. On the basis of the data analyses, items or factors may be dropped. Exploratory factor analysis is also planned.

Data from the pilot survey will be used to make final adjustments to the CCQM–PC. The final survey instrument will be made publicly available, at no charge, to prospective users, for use in research projects that aim to assess care coordination as it relates to quality care and healthcare outcomes, thereby helping to expand the evidence base for the care coordination construct and its associated processes. There is value, given where the field is now, in developing a survey of reasonable length that can be used for research purposes, but also can serve as the ''parent'' survey from which a smaller subset of items appropriate for quality improvement could be drawn.

A well-developed, psychometrically sound, practical survey of adult patients' experiences of care coordination in primary care settings, that covers key conceptual domains articulated through AHRQ's past work in this area, will help generate evidence that is needed to understand the relationship between care coordination processes and health outcomes, in addition to offering a way to explore other critical questions regarding care coordination.

The development of this research-focused survey is a critical step in moving toward the future development of measures of care coordination in primary care settings that can be used for accountability purposes, including those submitted for consideration of endorsement by the National Quality Forum. This will ensure that the measures or measure set is useful from a public reporting perspective to a variety of potential stakeholders, including patients seeking providers that engage in care coordination practices supported by the evidence base. The key target audiences for the use of the survey are researchers and, ultimately, payers (including health insurance plans, employers, and entities such as the Centers for Medicare & Medicaid Services), although use by health systems and individual primary care practices is also envisioned.

Estimated Annual Respondent Burden

Exhibit 1 shows the total estimated annualized burden hours for the CCQM–PC pilot survey (2,022 hours), including burden for survey respondents (1,890 hours) and practice staff (132 hours). With respect to the burden on CCQM–PC survey respondents, thirty practices will be sampled, with the survey sent to 375 prospective respondents per sample. A 40% response rate (in keeping with response rates on other CAHPS II+ and CAHPSS-like surveys of similar length and mode) will yield 150 respondents per practice. Total respondents were calculated by multiplying the number of practices by the respondents per practice, for a total of 4,500 (i.e., 150 × 30 = 4,500). The survey has 102 items (79 assessment items, 4 items about healthcare services sought in the past 12 months, and 19 items that assess participant characteristics such as demographics), with an estimated completion time of 25 minutes (.42 hours) per survey response. This estimate is based on the length of previous CAHPS® surveys of comparable length that have been administered to similar populations.

Burden hours for participating practices are calculated based on the total burden to one physician/administrator and one other clinician to complete the MHI–LV. The measure author recommends that both physician and non-physician viewpoints are considered in the PCP's response, thus the estimate is based on an assumption that two clinicians per practice will complete the MHI–LV process of care items together, with only one of the clinicians (i.e., the physician/administrator) completing the items on practice characteristics. Contract staff from AIR will ensure that practices realize there is no burden to them on the MHI–LV other than the time required to fill out the MHI–LV tool (i.e., they can ignore the measure author's reference in the instructions to a companion patient tool associated with the MHI–LV).

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS FOR CCQM–PC SURVEY PILOT TEST BY ENTITY

CCQM–PC survey	4,500	1	0.42	1,890
MHI–LV: [1] Physician/administrator	30	1	2.33	70
MHI–LV: Non-physician clinician	30	1	2.08	62
Total				2,022

[1] The Instructions for completing the MHI–LV recommend that a physician/administrator and a non-physician clinician each fill out the index separately. So, even though it is one form as reproduced in Appendix B, we have two rows in the table to describe the burden of the two individuals. There are a series of questions on the first two pages of the index which simply require administrative information and would only need to be completed once. We assume that the administrator would complete these and so the time required for the administrator to

Exhibit 2 shows the estimated annualized cost burden associated with the pilot survey administration. The total cost burden is estimated to be $51,228 for the one-time survey pilot.

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN FOR CCQM–PC SURVEY PILOT TEST BY ENTITY

Survey Respondents	1,890	[1] $22.33	$42,204
Physician/Administrator	70	[2] 88.43	190
Non-physician Clinician	62	[3] 45.71	2,834
Total Overall	2022	n/a	51,228

[1] Average wage for civilian workers, *http://www.bls.gov/news.release/ocwage.htm.*

[2] Average wage for family and general practitioners, *http://www.bls.gov/news.release/ocwage.htm.*

[3] Average wage for nurse practitioners, *http://www.bls.gov/news.release/ocwage.htm.*

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: October 6, 2014.

Richard Kronick,

Director.

[FR Doc. 2014–24513 Filed 10–15–14; 8:45 am]

BILLING CODE 4160–90–M

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: ''Continuing Education for Comparative Effectiveness Research Survey.'' 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.

This proposed information collection was previously published in the **Federal Register** on August 4th, 2014 and allowed 60 days for public comment. AHRQ did not receive any substantive comments. The purpose of this notice is to allow an additional 30 days for public comment.

DATES: Comments on this notice must be received by November 17, 2014.

ADDRESSES: Written comments should be submitted to: AHRQ's OMB Desk Officer by fax at (202) 395–6974 (attention: AHRQ's desk officer) or by email at *OIRA_submission@omb.eop.gov* (attention: AHRQ's desk 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

Continuing Education for Comparative Effectiveness Research Survey

Patient-centered outcomes research (PCOR) is an area that has seen increased focus from research agencies and other government entities. Also known as comparative effectiveness research, PCOR is the focus of AHRQ's Effective Health Care (EHC) program, which has the mission of providing health care decisionmakers (e.g., patients, health care providers, purchasers, and policymakers) with recent evidence-based information about the harms, benefits, and effectiveness of various treatment options by comparing medical devices, surgeries, tests, drugs, or ways to deliver health care.

The EHC program was created in response to Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and became the first federal program to conduct PCOR and disseminate those findings to the public. AHRQ works with researchers, academic organizations, and research centers through the EHC program on work relating to methods, training, and dissemination of products to a variety of stakeholders to help spread awareness and knowledge about PCOR. It is important for AHRQ to be able to measure the effectiveness of these products, which include training modules and publications, specifically around how they are affecting health care professionals' understanding, awareness, and use of PCOR and its related concepts. It is also important for AHRQ to be able to identify ways to improve how this information is being disseminated to the medical community.

The Continuing Education for Comparative Effectiveness Research Project is designed to provide online continuing education materials that inform physicians and other health care providers about patient-centered health research from the EHC Program, specifically comparative effectiveness research reports, and other government-funded comparative clinical effectiveness research. Online multimedia continuing education modules based on the Effective Health Care Program *http://www.effectivehealthcare.ahrq.gov/tools-and-resources/cmece-activities/* comparative effectiveness research reports will be planned, developed, disseminated, and promoted. In addition, data will be collected on the modules to assess their effectiveness and impact.

This study is being conducted by AHRQ through its contractor, Hayes Inc. (Hayes) and Hayes' subcontractors, Deloitte Consulting LLP (Deloitte), pursuant to AHRQ's statutory authority to support the agency's dissemination of comparative clinical effectiveness research findings. 42 U.S.C. 299b–37(a)–(c).

Method of Collection

To achieve the goals of this project, the following data collection will be implemented: (1) Each training module will involve one follow-up questionnaire that would be administered six months after the completion of the course for the purposes of tracking the longer-term effectiveness of the modules.

This data collection will help to meet AHRQ's objectives to:

1. Understand the extent to which these online continuing education modules based on the EHC Program comparative effectiveness research reports improve knowledge of each topic and change participants' awareness of, attitude towards, and/or confidence to apply CER in their clinical practice.
2. Track information about the dissemination efforts employed for CE/CER information specific to the modules, and the uptake of AHRQ's other EHC Program materials as a result of the project, including the Clinician and Consumer Summaries when available.
3. Determine implementation practices (e.g. changes in practice behavior or implementation of the information conveyed in the modules) that occur as a result of the learning.
4. Identify opportunities for improving the presentation and delivery of CE modules by gathering information on the participants' reactions to the modules and to the faculty presenters through the post-event evaluation assessment.

AHRQ will use the information collected through this Information Collection Request to assess the short- and long-term progress in achieving the dissemination and implementation aims of the Continuing Education project.

Estimated Total Respondent Burden

Exhibit 1 provides information on the estimated time to complete the data collection survey. These educational activities are enduring training modules and will be available for a 2-year period. The AHRQ Continuing Education for Comparative Effectiveness Research