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.

Sharon B. Arnold,

Acting Director.

[FR Doc. 2017–09090 Filed 5–4–17; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality; Notice of Meetings

AGENCY: Agency for Healthcare Research and Quality (AHRQ), HHS.

ACTION: Notice of five AHRQ subcommittee meetings.

SUMMARY: The subcommittees listed below are part of AHRQ's Health Services Research Initial Review Group Committee. Grant applications are to be reviewed and discussed at these meetings. Each subcommittee meeting will commence in open session before closing to the public for the duration of the meeting. These meetings will be closed to the public in accordance with 5 U.S.C. App. 2 section 10(d), 5 U.S.C. 552b(c)(4), and 5 U.S.C. 552b(c)(6).

DATES: See below for dates of meetings:

1. *Health Care Research and Training (HCRT)*
   Date: May 25–26, 2017 (Open from 8:00 a.m. to 8:30 a.m. on May 25 and closed for remainder of the meeting)
2. *Healthcare Information Technology Research (HITR)*
   Date: June 7–9, 2017 (Open from 6:00 p.m. to 6:30 p.m. on June 7 and closed for remainder of the meeting)
3. *Health System and Value Research (HSVR)*
   Date: June 14–15, 2017 (Open from 8:30 a.m. to 9:00 a.m. on June 14 and closed for remainder of the meeting)
4. *Healthcare Effectiveness and Outcomes Research (HEOR)*
   Date: June 14–15, 2017 (Open from 8:30 a.m. to 9:00 a.m. on June 14 and closed for remainder of the meeting)
5. *Healthcare Safety and Quality Improvement Research (HSQR)*
   Date: June 22–23, 2017 (Open from 8:00 a.m. to 8:30 a.m. on June 22 and closed for remainder of the meeting)

ADDRESSES: (Below specifics where each hotel will be held)

Gaithersburg Marriott, 9751 Washingtonian Blvd., Gaithersburg, Maryland 20878.

FOR FURTHER INFORMATION CONTACT: (To obtain a roster of members, agenda or minutes of the non-confidential portions of the meetings.)

Mrs. Bonnie Campbell, Committee Management Officer, Office of Extramural Research Education and Priority Populations, Agency for Healthcare Research and Quality (AHRQ), 5600 Fishers Lane, Rockville, Maryland 20857, Telephone (301) 427–1554.

SUPPLEMENTARY INFORMATION:

In accordance with section 10 (a)(2) of the Federal Advisory Committee Act (5 U.S.C. App. 2), AHRQ announces meetings of the above-listed scientific peer review groups, which are subcommittees of AHRQ's Health Services Research Initial Review Group Committees. Each subcommittee meeting will commence in open session before closing to the public for the duration of the meeting. The subcommittee meetings will be closed to the public in accordance with the provisions set forth in 5 U.S.C. App. 2 section 10(d), 5 U.S.C. 552b(c)(4), and 5 U.S.C. 552b(c)(6) The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Agenda items for these meetings are subject to change as priorities dictate.

Sharon B. Arnold,

Acting Director.

[FR Doc. 2017–09130 Filed 5–4–17; 8:45 am]

BILLING CODE 4160–90–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 ''*The Re-engineered Visit for Primary Care.*''

This proposed information collection was previously published in the **Federal Register** on February 13, 2017 and allowed 60 days for public comment. AHRQ received one comment from 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 June 5, 2017.

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

The Re-Engineered Visit for Primary Care

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 project, The Re-engineered Visit for Primary Care, directly addresses the agency's goal to conduct research to enhance the quality of health care and reduce avoidable readmissions, which are a major indicator of poor quality and patient safety.

Research from AHRQ's Healthcare Cost and Utilization Project (HCUP) indicates that in 2011 there were approximately 3.3 million adult hospital readmissions in the United States. Adults covered by Medicare have the highest readmission rate (17.2 per 100 admissions), followed by adults covered by Medicaid (14.6 per 100 admissions) and privately insured adults (8.7 per

100 admissions). High rates of readmissions are a major patient safety problem and are associated with a range of adverse events, such as prescribing errors and misdiagnoses of conditions in the hospital and ambulatory care settings. Collectively these readmissions are associated with $41.3 billion in annual hospital costs, many of which potentially could be avoided.

In recent years, payer and provider efforts to reduce readmissions have proliferated. Many of these national programs have been informed or guided by evidence-based research, toolkits and guides, such as AHRQ's RED (Re-Engineered Discharge), STAAR (STate Action on Avoidable Readmission), AHRQ's Project BOOST (Better Outcomes by Optimizing Safe Transitions), the Hospital Guide to Reducing Medicaid Readmissions, and Eric Coleman's Care Transitions Intervention. These efforts have largely focused on enhancing practices occurring within the hospital setting, including the discharge process transitions among providers and between settings of care. While many of these efforts have recognized the critical role of primary care in managing care transitions, they have not had an explicit focus on enhancing primary care with the aim of reducing avoidable readmissions.

Evidence-based guidance to reduce readmissions and improve patient safety are comparatively lacking for the primary care setting. This gap in the literature is becoming more pronounced as primary care is increasingly serving as the key integrator across the health system as part of payment and delivery system reforms. This research project aims to address the important and unfulfilled need to improve patient safety and reduce avoidable readmissions within the primary care context.

AHRQ's goals in supporting this 30-month project are to build on the knowledge base from the inpatient settings, add to the expanding evidence base on preventing readmissions by focusing on the primary care setting, and provide insight on the components and themes that should be part of a re-engineered visit in primary care. This work will ultimately inform an effective intervention that can be tested in a diverse set of primary care clinics.

To meet AHRQ's goals and objectives, the agency awarded a task order to John Snow, Inc. (JSI) to conduct qualitative research using quality improvement to investigate the primary care-based transitional care workflow from the primary care staff, patient, and community agency perspective.

This research has the following goals:

1. Analyze current processes in the primary care visit associated with hospital discharge; and

2. Identify components of the re-engineered visit.

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

Method of Collection

To analyze current processes in the primary care visit associated with hospital discharge, the data collection is separated into seven smaller data collection activities to minimize research participant burden while still allowing for the collection of necessary data. Each of these tasks will be conducted at nine primary care sites:

1. *Primary care site organizational characteristics survey:* The purpose of this background information on the primary care site's organizational characteristics is to offer context for the work flow mapping. It will help make the work flow mapping process more efficient and reduce burden by only requesting information that is already known by each site contact. One person per primary care site will be engaged for this task.

2. *Primary care site patient characteristics survey:* The purpose of this background information on the primary care site's patients is to offer context for the work flow mapping. It will help make the work flow mapping process more efficient and reduce burden by only requesting information that is already known in the primary care practices' billing or clinical information systems. One person per primary care site will be engaged for this task.

3. *Work flow mapping preliminary interviews:* The purpose of this flow mapping ''pre-work'' is to engage individual primary care staff members to think about the current work flow map in order to set a foundation for the actual work flow mapping process. It is anticipated that eight individuals per primary care site will participate, for a total of 72 participants.

4. *Work flow mapping:* This collection will take place in a group meeting that brings together staff from various role types to collaborate in identifying their workflow processes involved in planning for and executing post-hospital follow up services for their patients. Based on feasibility, these may be smaller or larger group meetings, but the total burden on each role type participant is the same. The end goal of this meeting is to have enough information to develop an initial process flow map on paper. It is anticipated that 10 individuals per primary care site will participate, for a total of 90 participants.

5. *Work flow mapping follow-up interviews:* Once the initial process flow map is on paper, each role type will be asked to review to correct, add, or confirm detail to the document. Once the flow map has been edited and ratified by the primary care site staff, each role type will be asked specific questions regarding the flaws identified in the process flow for the failure mode effects analysis. It is anticipated that eight individuals per primary care site will participate, for a total of 72 participants.

6. *Patient Interviews:* As a complement to the work flow mapping, there will also be a process flow map developed from the patient's perspective. The purpose of the patient interviews is to capture patient perspectives on potential breakdowns in making the transition from the hospital to care in the primary care settings and to get, in their own words, information about the initial hospitalization and barriers to accessing follow-up care. One of the widely acknowledged limitations of the existing evidence based toolkits is that they are not designed with input from patients.

This has occurred despite the fact that clinical experience suggests that providers often fail to identify patient needs and concerns. Research has shown that there are cultural, social, and behavioral factors that may contribute to readmissions and assessing the patient's perspective can help to better understand the barriers to receiving appropriate follow-up care.

Patient and family interviews are increasingly common practices in efforts to improve care transitions and reduce readmissions, endorsed by CMS, the Institute for Healthcare Improvement, Kaiser Permanente, and others. This patient interview will collect unique information on the barriers to effective care transitions in the post-discharge period care, information which cannot be collected in other ways. It is anticipated that ten post-discharge patients per primary care site will be interviewed for a total of 90 patients.

7. *Community agency interviews:* As a complement to the work flow mapping, the process flow map developed will reflect the perspective of community

agencies affiliated with the primary care sites to assist patients. It is anticipated that five community agency representatives per primary care site will be interviewed.

The purpose of this data collection is to understand the key components that should be included in the re-engineered visit in primary care. The project team will examine the diverse settings, staff, and transitional care activities across a variety of primary care practices to identify key transitional care processes that impact patient outcomes, the challenges to implementing those processes, and ways to improve those processes.

The project team will distill the themes and principles that should be a part of the re-engineered visit and develop an outline and summary of its components, with a comparison/contrast of the components across sites and discussion of the generalizability of these components to different settings.

The results of this research will add to the expanding evidence base on preventing readmissions by focusing on the primary care setting, and provide insight on the components and themes that should be part of a re-engineered visit. This information will ultimately inform an effective intervention that can be tested in a diverse set of primary care clinics.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated burden hours to the respondents for providing all of the data needed to meet the project's objectives. The hours estimated per responses are based on the pilot project results.

For the primary care site organizational characteristics survey and patient characteristics survey, one person per each of the nine primary care sites will participate. Both surveys are anticipated to take 1.5 hours to complete.

For the work flow mapping preliminary interviews, we estimate that eight primary care staff per primary care site will participate, with each individual spending 0.5 hours in these interviews. For the work flow mapping group interview, we estimate that 10 primary care staff per primary care site will participate, with each individual spending 1.5 hours in these interviews. Finally, we estimate that eight primary care staff per primary care site will participate in the work flow mapping follow-up interviews, with each individual spending 0.5 hours in this data collection activity.

There will be 10 patients interviewed in association with each primary care site. These patient interviews are expected to take 0.5 hours per individual research participant.

Lastly, there will be five community agency staff members interviewed in association with each primary care site. These interviews are expected to take 1 hour per individual research participant.

Exhibit 2 shows the estimated cost burden for the respondents' time to participate in the project. The total annualized cost burden is estimated at $11,500.30.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Primary care site organizational characteristics survey	9	1	1.5	13.5
Primary care site patient characteristics survey	9	1	1.5	13.5
Workflow mapping preliminary interview	72	1	0.5	36
Workflow mapping group interview	90	1	1.5	135
Workflow mapping follow-up interview	72	1	0.5	36
Patient interview	90	1	0.5	45
Community agency interview	45	1	1	45
Total	387	n/a	n/a	2,628

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate *	Total cost burden
Primary care site organizational characteristics survey	9	13.5	[a] $40.41	$545.54
Primary care site patient characteristics survey	9	13.5	[a] 40.41	545.54
Workflow mapping preliminary interview	72	36	[a] 40.41	1,454.76
Workflow mapping group interview	90	135	[a] 40.41	5,455.35
Workflow mapping follow-up interview	72	36	[a] 40.41	1,454.76
Patient interview	90	45	[b] 23.23	1,045.35
Community agency interview	45	45	[c] 22.20	999.00
Total	387	n/a	n/a	11,500.30

* For hourly average wage rates, mean hourly wages from the Bureau of Labor Statistics (BLS) May 2015 national occupational employment wage estimates were used. *http://www.bls.gov/oes/current/oes_nat.htm#00–0000.*

[a] Participants will include a mix of providers and front desk staff; therefore a blended rate for these tasks are used including Nurse ($33.55), Medical Assistant ($15.01 [1]), Front Desk Staff ($13.38 [2]), Program Director ($32.56), Pharmacist ($56.96), Physician ($91.60), Behavioral health provider ($22.03).

[b] Based upon the mean wages for consumers (all occupations).

[c] Based upon the mean wages for Social Workers.

[1] *http://www.bls.gov/oes/current/oes319092.htm.*

[2] *http://www.bls.gov/oes/current/oes434171.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.

Sharon B. Arnold,

Acting Director.

[FR Doc. 2017–09097 Filed 5–4–17; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Meeting of the Community Preventive Services Task Force (Task Force)

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice of meeting.

SUMMARY: The Centers for Disease Control and Prevention (CDC) within the Department of Health and Human Services announces the next meeting of the Community Preventive Services Task Force (Task Force) on June 14–15, 2017 in Atlanta, Georgia.

DATES: The meeting will be held on Wednesday, June 14, 2017 from 8:30 a.m. to 6:00 p.m. EDT and Thursday, June 15, 2017 from 8:30 a.m. to 1:00 p.m. EDT.

ADDRESSES: The Task Force Meeting will be held at the CDC Edward R. Roybal Campus, Centers for Disease Control and Prevention Headquarters (Building 19), 1600 Clifton Road NE., Atlanta, GA 30329. You should be aware that the meeting location is in a Federal government building; therefore, strict Federal security measures are applicable. For additional information, please see Roybal Campus Security Guidelines under **SUPPLEMENTARY INFORMATION**. Information regarding meeting logistics will be available on the Community Guide Web site (*www.thecommunityguide.org*) closer to the date of the meeting.

Meeting Accessability: This space-limited meeting is open to the public. All meeting attendees must register to ensure completion of required security procedures and access to the CDC's Global Communications Center.

Public Comment: A public comment period, limited to three minutes per person, will follow the Task Force's discussion of each systematic review. Individuals wishing to make public comments must indicate their desire to do so in advance by providing their name, organizational affiliation, and the topic to be addressed (if known) with their registration. Public comments will become part of the meeting summary. Public comment is not possible via Webcast.

U.S. citizens must register by June 7, 2017. To satisfy security requirements, Non U.S. citizens must register by May 29, 2017. Failure to register by the dates identified could result in the inability to attend the Task Force meeting.

Meeting Accessibility: This meeting is available to the public via Webcast. CDC will send the Webcast URL to registrants upon receipt of their registration. All meeting attendees must register to receive the webcast information. CDC will email webcast information from the *CPSTF@cdc.gov* mailbox.

FOR FURTHER INFORMATION/REGISTRATION, CONTACT: Onslow Smith, Center for Surveillance, Epidemiology and Laboratory Services, Centers for Disease Control and Prevention, 1600 Clifton Road NE., MS–E–69, Atlanta, GA 30329, phone: (404) 498–6778, email: *CPSTF@cdc.gov*.

SUPPLEMENTARY INFORMATION:

Background on the CPSTF: The Task Force is an independent, nonpartisan, nonfederal, and unpaid panel. Its members represent a broad range of research, practice, and policy expertise in prevention, wellness, health promotion, and public health, and are appointed by the CDC Director. The Task Force was convened in 1996 by the Department of Health and Human Services (HHS) to identify community preventive programs, services, and policies that increase healthy longevity, save lives and dollars, and improve Americans' quality of life. CDC is mandated to provide ongoing administrative, research, and technical support for the operations of the Task Force. During its meetings, the Task Force considers the findings of systematic reviews on existing research and practice-based evidence and issues recommendations. Task Force recommendations are not mandates for compliance or spending. Instead, they provide information about evidence-based options that decision makers and stakeholders can consider when they are determining what best meets the specific needs, preferences, available resources, and constraints of their jurisdictions and constituents. The Task Force's recommendations, along with the systematic reviews of the evidence on which they are based, are compiled in the *Guide to Community Preventive Services (The Community Guide).*

At the meetings, the Task Force considers systematic reviews and issues findings and recommendations based on the reviews. Task Force recommendations provide information about evidence-based options that decision makers and stakeholders can consider when they are determining what best meets the specific needs, preferences, available resources, and constraints of their jurisdictions and constituents.

Matters proposed for discussion:* Diabetes prevention: Diabetes Prevention and Control (Effectiveness of Mobile Phone Applications to Improve Glycemic Control (HbA1c) in the Self-management of Diabetes); Obesity Prevention and Control (Economics of School-based Interventions for Obesity Prevention Availability of Healthy Food and Beverage (AHFB) and Snack Food and Beverage (SFB)); Physical Activity (Effectiveness of Activity Monitors for Increasing Physical Activity in Adults with Overweight or Obesity); Nutrition (Telehealth Methods to Deliver Dietary Interventions in Adults with Chronic Disease); and Women's Health (Effectiveness of Interventions for the Primary Prevention of Intimate Partner Violence and Sexual Violence Among Youth). The agenda is subject to change without notice.

Roybal Campus Security Guidelines: The Edward R. Roybal Campus is the headquarters of the CDC and is located at 1600 Clifton Road NE., Atlanta, Georgia. The meeting is being held in a Federal government building; therefore, Federal security measures are applicable.

All meeting attendees must RSVP by the dates outlined under *Meeting Accessability*. In planning your arrival time, please take into account the need to park and clear security. All visitors must enter the Edward R. Roybal