

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate *	Total cost burden
Registration Form	85	7	^a 54.68	\$383
Health Plan Information Form	75	150	^a 54.68	8,202
Data Use Agreement	75	6	^b 96.22	577
Questionnaire and Data Files Submission	75	300	^c 43.07	12,921
Total	310	463	NA	\$22,083

* National Compensation Survey: Occupational wages in the United States May 2018, “U.S. Department of Labor, Bureau of Labor Statistics.”

^a Based on the mean hourly wage for Medical and Health Services Managers (11–9111).

^b Based on the mean hourly wage for Chief Executives (11–1011).

^c Based on the mean hourly wages for Computer Programmer (15–1131).

Request for Comments

In accordance with the Paperwork Reduction Act of 1995, 44 U.S.C. 3501–3521, 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: April 7, 2020.

Virginia Mackay-Smith,
Associate Director.

[FR Doc. 2020–07662 Filed 4–10–20; 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: “*Evaluating the Dissemination and Implementation of PCOR to Increase Referral, Enrollment, and Retention through Automatic Referral to Cardiac Rehabilitation (CR) with Care Coordination.*” This proposed information collection was previously published in the **Federal Register** on February 4th, 2020 and allowed 60 days for public comment. AHRQ did not receive comments from 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 30 days after date of publication of this notice.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to www.reginfo.gov/public/do/PRAMain. Find this particular information collection by selecting “Currently under 30-day Review—Open for Public Comments” or by using the search function.

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

Evaluating the Dissemination and Implementation of PCOR To Increase Referral, Enrollment, and Retention Through Automatic Referral to Cardiac Rehabilitation (CR) With Care Coordination

The aim of AHRQ’s TAKEheart project is to (a) raise awareness about the benefits of cardiac rehabilitation (CR) after myocardial infarction or coronary revascularization, then to (b)

disseminate knowledge about the best practices to increase referrals to CR, and, finally, (c) to increase CR uptake. Currently over two-thirds of eligible cardiac patients are not referred to CR despite extensive evidence of its effectiveness in preventing subsequent morbidity; national estimates of referral range from 10–34%. To help improve CR rates, the Million Hearts® Cardiac Rehabilitation Collaborative—an initiative co-led by the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS)—developed a Cardiac Rehabilitation Change Package (CRCP) and established a national goal of 70% participation in CR by 2022 for eligible patients. Recognizing that widespread adoption of the CRCP could help hospitals enhance CR rates, the CDC turned to AHRQ with a request that AHRQ consider disseminating and implementing evidence for CR and practices that promote CR. The CRCP is designed to facilitate this dissemination and implementation process. AHRQ reviewed this request in the context of its Patient Centered Outcomes Research Dissemination and Implementation initiative and judged the CDC nomination to have a high level of fit with AHRQ’s criteria of having a substantial evidence base, high potential impact, and high feasibility for wide dissemination and implementation. Outreach with stakeholders indicates that this initiative aligns well but does not duplicate work by NIH; PCORI; CMS and CDC.

The core recommendations in the CDC package are, first to spread adoption of automatic referral system—where patients after cardiovascular events are referred by the Electronic Health Record to rehabilitation unless the cardiologist actively decides not to refer because of medical ineligibility. The second core recommendation is use of a care coordinator to guide patients through referral has resulted in the most significant increases in referral to CR.

TAKEheart will facilitate dissemination and implementation of Automatic Referral with Care Coordination in selected, diverse hospitals nationwide which demonstrate their readiness.

AHRQ will evaluate TAKEheart to assess:

- The extent and effectiveness of the dissemination and implementation efforts;
- the uptake and usage of Automatic Referral with Care Coordination; and
- levels of referral to CR at the end of the intervention.

Evaluation results will be used to improve the intervention and to provide guidance for future AHRQ Dissemination and Implementation projects. Two cohorts of “Partner Hospitals,” up to 125 hospitals in total, will receive training that disseminates the importance of CR and ways to enhance CR referral and then engages them in efforts to implement Automatic Referral with Care Coordination over twelve month periods. The evaluation will ascertain the diversity of hospitals engaged, the activities that contributed to (or hindered) their efforts, and the types of support which they report having been most (and least) useful. This information will be used to improve recruitment, technical assistance, and tools for the second cohort.

In addition, hospitals—including those involved in the dissemination and implementation support for Partner Hospitals—will be invited to attend Affinity Group virtual meetings organized around specific topics of interest which are not intrinsic to Automatic Referral with Care Coordination. Hospital staff engaged in Affinity Groups will create a vibrant Learning Community. The evaluation will determine which Affinity Groups engaged the most participants of the Learning Community, and which resources participants determined the most useful. This information will be used to develop resources which will be available on a new, permanent website dedicated to improving CR.

This study is being conducted by AHRQ through its contractor, Abt Associates Inc., pursuant to AHRQ’s statutory authority to disseminate government-funded research relevant to comparative clinical effectiveness research. 42 U.S.C. 299b–37(a).

Method of Data Collection

To collect data on the many facets of the intervention, we will use multiple data collection tools, each of which has a specific purpose and set of respondents.

1. Partner Hospital Champion Survey. Each Partner Hospital will designate a “Champion,” who will coordinate activities associated with implementing Automatic Referral with Care Coordination at the hospital, and provide the Champion’s name and email address. The Champion may have any role in the hospital, although they are expected in relevant positions, such as cardiologists or quality improvement managers. We will conduct online surveys of 125 Champions (one Champion per hospital). We will use the email addresses to send the Champion a survey at two points: Seven months after the start of dissemination and implementation to the Partner Hospitals and at the end of the 12-month dissemination and implementation period. The first survey will focus on four constructs. First, it will capture data about the hospital context, such as whether it had prior experience customizing an electronic medical record (EMR) or is a safety net hospital. Second, it will address the hospital’s decision to participate in TAKEheart. Third, it will capture data on the CR programs the hospital refers to, whether the number or type has changed, and why. Fourth, it will collect feedback on the training and technical assistance received. The second survey will focus on three constructs. First, it will collect feedback on the TAKEheart components, including training, technical assistance, and use of the website. Second, we will ask about the hospitals’ response to participating in TAKEheart, such as changes to referral workflow or CR programs. Third, we will ask those Partner Hospitals which have not completed the process of implementing Automatic Referral with Care Coordination whether they anticipate continuing to work towards that goal and their confidence in succeeding.

2. Partner Hospital Interviews.

a. Interviews with Partner Hospital Champions. We will select, from each cohort, eight Partner Hospitals that demonstrated a strong interest in addressing underserved populations or reducing disparities in participation in cardiac rehabilitation. We will conduct a key informant interview with the Champion of each selected Partner Hospital to delve into their response to the information and guidance that was disseminated to them and to describe how they are addressing the needs of underserved populations by implementing Automatic Referral with Care Coordination.

b. Interviews with Partner Hospital cardiologists. We will select, from each cohort, eight hospitals based on criteria

such as hospitals which serve specific populations, or have the same EMRs, which will inform their experience customizing the EMR. We will conduct semi-structured interviews with one cardiologist at each of the selected hospitals twice. In the second month of the cohort for dissemination and implementation, we will ask about their needs, concerns, and expectations of the program. In the 11th month of the cohort implementation, we will determine whether their concerns were addressed appropriately and adequately.

c. Interviews with Partner Hospitals that withdraw. We expect that a small number of Partner Hospitals may withdraw from the cohort. We will identify these hospitals by their lack of participation in training and technical assistance events; technical assistance providers will confirm their withdrawal. We will interview up to nine withdrawing hospitals to better understand the reason for withdrawal (e.g., a merger resulted in a loss of support for the intervention, Champion left), as well as facilitators of, and barriers to, each hospital’s approach to implementing Automatic Referral with Care Coordination. If more than nine hospitals withdraw, we will cease interviewing.

3. Learning Community Participant Survey. We will conduct online surveys of 250 currently active Learning Community participants at two points in time, in months 18 and 31 of the project. We will administer the survey by sending a link to an online survey to email addresses entered by virtual meeting participants during registration. The email will describe the purpose of the survey.

4. Learning Community Follow-up Survey. We will conduct a brief online survey with up to 15 Learning Community participants following the final virtual meeting for each of 10 Affinity Groups, to ascertain whether the hospitals were able to act on what they learned during the session. The total sample will be 150 Learning Community participants.

Estimated Annual Respondent Burden

Exhibit 1 presents estimates of the reporting burden hours for the data collection efforts. Time estimates are based on prior experiences and what can reasonably be requested of participating health care organizations. The number of respondents listed in column A, Exhibit 1 reflects a projected 90% response rate for data collection effort 1, and an 80% response rate for efforts 3 and 4 below.

1. Partner Hospital Champion Survey. We assumed 113 hospital champions

will complete the survey based on a 90% response rate. It is expected to take up to 45 minutes to complete for a total of 169.5 hours to complete.

2. Partner Hospital Interviews. In-depth interviews will occur with select Partner Hospital staff.

a. Interviews with Partner Hospital Champions. We will have a single, 90 minute interview with eight Partner Hospital Champions, in each cohort, from Partner Hospitals that have a common characteristic of particular interest, for a total of 24 hours.

b. Interviews with Partner Hospital cardiologists. We will hold individual, up-to-30 minute interviews with eight cardiologists, twice in each cohort, for a total of 16 hours.

c. Interviews with Partner Hospitals that withdraw. We will interview up to nine withdrawing hospitals for no more than 20 minutes to better understand the reason for withdrawal as well as facilitators and barriers, for a total of 2.7 hours.

3. Learning Community Participant Survey. We assumed 200 Learning Community participants will complete

the survey based on an 80% response rate. It is expected to take up to 15 minutes to complete each survey for a total of 100 hours.

4. Learning Community Follow-up Survey. We will conduct a brief, up to 10 minute, online survey of participants of each of just ten selected Affinity Groups at two months after the virtual meeting. We assumed 120 Learning Community participants will complete the survey based on an 80% response rate. It is expected to take up to 15 minutes to complete each survey for a total of 20.4 hours.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Data collection method or project activity	A. Number of respondents	B. Number of responses per respondent	C. Hours per response	D. Total burden hours
1. Partner Hospital Champion Survey *	113	2	0.75	169.5
2a. Interviews with Partner Hospital Champions	16	1	1.5	24.0
2b. Interviews with Partner Hospital Cardiologists	16	2	0.5	16.0
2c. Interviews with Partner Hospitals that withdraw	9	1	0.3	2.7
3. Learning Community Survey **	200	2	0.25	100.0
4. Learning Community Follow-up Survey **	120	1	0.17	20.4
Total	474			332.6

* Number of respondents (Column A) reflects a sample size assuming a 90% response rate for this data collection effort.

** Number of respondents (Column A) reflects a sample size assuming an 80% response rate for this data collection effort.

Exhibit 2, below, presents the estimated annualized cost burden associated with the respondents' time to participate in this research. We obtained median hourly wage rates for relevant occupations from the Bureau of Labor & Statistics on "Occupational Employment Statistics, May 2018 Occupation Profiles" found at the

following URL on October 1, 2019: https://www.bls.gov/oes/current/oes_stru.htm#15-0000. We assumed that half the Partner Hospital Champions will be cardiologists and half will be Quality Improvement managers. We calculated the hourly rate of \$72.27 by averaging the median hourly wage rate for cardiologists (\$96.58, occupation code

29-1069) and medical and health services managers (\$47.95, occupation code 11-1141). The occupation of medical and health services managers has been used for quality improvement staff in other AHRQ projects. The total cost burden is estimated to be about \$21,497.

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Data collection method or project activity	A. Number of respondents	B. Total burden hours	Average hourly wage rate	Total cost burden
1. Partner Hospital Champion Survey *	113	169.5	\$72.27	\$12,250
2a. Interviews with Partner Hospital Champions	16	24.0	72.27	1,734
2b. Interviews with Partner Hospital Cardiologists	16	16.0	96.58	1,545
2c. Interviews with Partner Hospitals that withdraw	9	2.7	72.27	195
3. Learning Community Survey **	200	100.0	47.95	4,795
4. Learning Community Follow-up Survey **	120	20.4	47.95	978
Total	474	332.6		21,497

* Number of respondents (Column A) reflects a sample size assuming a 90% response rate for this data collection effort.

** Number of respondents (Column A) reflects a sample size assuming an 80% response rate for this data collection effort.

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 healthcare 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: April 7, 2020.

Virginia L. Mackay-Smith,
Associate Director.

[FR Doc. 2020-07661 Filed 4-10-20; 8:45 am]

BILLING CODE 4160-90-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Docket No. CDC-2020-0001; NIOSH-333]

Developing a Workplace Supported Recovery Program: A Strategy for Assisting Workers and Employers With the Nation's Opioid and Substance Use Disorder Epidemics; Request for Information; Extension of Comment Period

AGENCY: Centers for Disease Control and Prevention, HHS.

ACTION: Extension of comment period.

SUMMARY: On February 26, 2020, the National Institute for Occupational Safety and Health (NIOSH), within the Center for Disease Control and Prevention (CDC), opened a docket to obtain public input on a NIOSH plan to develop resources and conduct research on the topic of workplace supported recovery. Workplace supported recovery programs (WSRPs) assist workers and employers facing the nation's crisis related to the misuse of opioids and other drugs, and related substance disorders. Comments were to be received by April 27, 2020. NIOSH is extending the comment period to close on July 27, 2020, to allow stakeholders and other interested parties sufficient time to respond.

DATES: The comment period for the document published on February 26, 2020 (85 FR 11085), is extended. Comments must be received by July 27, 2020.

ADDRESSES: You may submit written comments, identified by docket numbers CDC-2020-0001 and NIOSH-333, by either of the following two methods:

- *Federal eRulemaking Portal:* <http://www.regulations.gov>. Follow the instructions for submitting comments.
 - *Mail:* National Institute for Occupational Safety and Health, NIOSH Docket Office, 1090 Tusculum Avenue, MS C-34, Cincinnati, Ohio 45226-1998.
- Instructions:* All information received in response to this notice must include

the agency name and docket number [CDC-2020-0001; NIOSH-333]. All relevant comments received will be posted without change to <http://www.regulations.gov>, including any personal information provided.

FOR FURTHER INFORMATION CONTACT: L. Casey Chosewood, NIOSH, 1600 Clifton Road NE; Mailstop V24-4, Atlanta, GA 30329; phone: 404-498-2483 (not a toll-free number); email: tw@cdc.gov.

SUPPLEMENTARY INFORMATION: NIOSH published a request for information in the *Federal Register* on February 26, 2020 (85 FR 11085) regarding the planned development of resources and conduct of research on the topic of workplace supported recovery programs (WSRPs). This notice announces the extension of the comment period until July 27, 2020.

John J. Howard,

Director, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention.

[FR Doc. 2020-07683 Filed 4-10-20; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Community Living

Intent To Award a Single-Source Supplement for the Amputee Coalition of America, Inc. for the National Limb Loss Resource Center Cooperative Agreement

ACTION: Notice; intent to award a single-source supplement.

SUMMARY: The Administration for Community Living (ACL) announces the intent to award a single-source supplement to the current cooperative agreement held by the Amputee Coalition of America, Inc. for the National Limb Loss Resource Center (NLLRC). The purpose of this project is to expand on current grant activities occurring across communities. These activities include programs that promote independence, community living, and the adoption of healthy behaviors that promote wellness and prevent and/or reduce chronic conditions associated with limb loss and increase partnerships and collaborations with ACL programs that will benefit all people living with limb loss or limb differences. The administrative supplement for FY 2020 will be for \$500,000, bringing the total award for FY 2020 to \$3,884,003.

FOR MORE INFORMATION CONTACT: For further information or comments regarding this program supplement, contact Elizabeth Leef, U.S. Department

of Health and Human Services, Administration for Community Living, Administration on Disabilities, Independent Living Administration at (202) 475-2486 and; email Elizabeth.leef@acl.hhs.gov.

SUPPLEMENTARY INFORMATION: The additional funding will not be used to begin new projects. The funding will be used to enhance and expand existing programs that can serve an increased number of veterans and people living with limb loss and limb differences by providing increased technical assistance activities; promoting health and wellness programs; addressing healthcare access issues, including maternity care; promoting the adoption of healthy behaviors with the objective of preventing and/or reducing chronic conditions associated with limb loss; increasing partnerships and collaborations with ACL programs that will benefit all people living with limb loss or limb differences; enhancing and expanding the evaluation activities currently under way; and enhancing website capacities for improved information dissemination.

Program Name: National Limb Loss Resource Center

Recipient: The Amputee Coalition of America, Inc.

Period of Performance: The supplement award will be issued for the second year of the five-year project period of April 1, 2019, through March 29, 2024.

Total Supplement Award Amount: \$500,000 in FY 2020.

Award Type: Cooperative Agreement Supplement.

Statutory Authority: This program is authorized under Section 317 of the Public Health Service Act (42 U.S.C. 247(b-4)); Consolidated and Further Continuing Appropriations Act, 2015, Public Law 113-235 (Dec. 16, 2014).

Basis for Award: The Amputee Coalition of America, Inc. is currently funded to carry out the objectives of this program, entitled *The National Limb Loss Resource Center* for the period of April 1, 2019, through March 29, 2024. Almost 2 million Americans have experienced amputations or were born with limb difference and another 28 million people in our country are at risk for amputation. The supplement will enable the grantee to carry their work even further, serving more people living with limb loss and/or limb differences and providing even more comprehensive training and technical assistance in the development of long-term supportive services. The additional funding will not be used to begin new projects or activities. The NLLRC will