President) 1 Memorial Drive, Kansas City, Missouri 64198–0001:

1. *WSB Financial, Inc., Leesburg, Florida;* to become a bank holding company by acquiring J&M Bancshares, Inc., and thereby indirectly acquiring The Walton State Bank, both of Walton, Kansas.

Board of Governors of the Federal Reserve System.

Michele Taylor Fennell,

Deputy Associate Secretary of the Board.

[FR Doc. 2022–22897 Filed 10–20–22; 8:45 am]

BILLING CODE 6210–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisitions of Shares of a Bank or Bank Holding Company

The notificants listed below have applied under the Change in Bank Control Act (Act) (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire shares of a bank or bank holding company. The factors that are considered in acting on the applications are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The public portions of the applications listed below, as well as other related filings required by the Board, if any, are available for immediate inspection at the Federal Reserve Bank(s) indicated below and at the offices of the Board of Governors. This information may also be obtained on an expedited basis, upon request, by contacting the appropriate Federal Reserve Bank and from the Board's Freedom of Information Office at *https://www.federalreserve.gov/foia/request.htm.* Interested persons may express their views in writing on the standards enumerated in paragraph 7 of the Act.

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 November 4, 2022.

A. Federal Reserve Bank of St. Louis (Holly A. Rieser, Senior Manager) P.O. Box 442, St. Louis, Missouri 63166–2034. Comments can also be sent electronically to *Comments.applications@stls.frb.org*:

1. *Alberta Fleming, Michael F. Fleming, and the MFF Trust, Michael F. Fleming, as trustee, all of Litchfield, Illinois; Susan K. Wetzel, and the SKW Trust, Susan K. Wetzel, as trustee, all of Hillsboro, Illinois;* together as a family control group, a group acting in concert, to retain voting shares of Litchfield Bancshares Company, Inc., and thereby indirectly retain voting shares of The Litchfield National Bank, both of Litchfield, Illinois.

B. Federal Reserve Bank of Dallas (Karen Smith, Director, Applications) 2200 North Pearl Street, Dallas, Texas 75201–2272:

1. *Cynthia S. Shaw, Austin, Texas;* to acquire additional voting shares of Big Bend Bancshares Corporation, and indirectly acquire additional voting shares of Big Bend Banks, N.A. dba The Marfa National Bank, both of Marfa, Texas.

Board of Governors of the Federal Reserve System.

Michele Taylor Fennell,

Deputy Associate Secretary of the Board.

[FR Doc. 2022–22894 Filed 10–20–22; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Supplemental Evidence and Data Request on Strategies for Integrating Behavioral Health and Primary Care

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

ACTION: Request for supplemental evidence and data submissions.

SUMMARY: The Agency for Healthcare Research and Quality (AHRQ) is seeking scientific information submissions from the public. Scientific information is being solicited to inform our review on *Strategies for Integrating Behavioral Health and Primary Care,* which is currently being conducted by the AHRQ's Evidence-based Practice Centers (EPC) Program. Access to published and unpublished pertinent scientific information will improve the quality of this review.

DATES: *Submission Deadline* on or before November 21, 2022.

ADDRESSES:

Email submissions: epc@ahrq.hhs.gov.

Print submissions:

Mailing Address: Center for Evidence and Practice Improvement, Agency for Healthcare Research and Quality, Attn: EPC SEADs Coordinator, 5600 Fishers Lane, Mail Stop 06E53A, Rockville, MD 20857.

Shipping Address (FedEx, UPS, etc.): Center for Evidence and Practice Improvement, Agency for Healthcare Research and Quality, Attn: EPC SEADs Coordinator, 5600 Fishers Lane, Mail Stop 06E77D, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: Jenae Benns, Telephone: 301–427–1496 or email: *epc@ahrq.hhs.gov.*

SUPPLEMENTARY INFORMATION: The Agency for Healthcare Research and Quality has commissioned the Evidence-based Practice Center (EPC) Program to complete a review of the evidence for *Strategies for Integrating Behavioral Health and Primary Care.* AHRQ is conducting this systematic review pursuant to Section 902 of the Public Health Service Act, 42 U.S.C. 299a. The EPC Program is dedicated to identifying as many studies as possible that are relevant to the questions for each of its reviews. In order to do so, we are supplementing the usual manual and electronic database searches of the literature by requesting information from the public (*e.g.,* details of studies conducted). We are looking for studies that report on Strategies for Integrating Behavioral Health and Primary Care, including those that describe adverse events. The entire research protocol is available online at: *https://effectivehealthcare.ahrq.gov/products/strategies-integrating-behavioral-health/protocol.* This is to notify the public that the EPC Program would find the following information on Strategies for Integrating Behavioral Health and Primary Care helpful:

- A list of completed studies that your organization has sponsored for this indication. In the list, please *indicate whether results are available on ClinicalTrials.gov along with the ClinicalTrials.gov trial number.*
- *For completed studies that do not have results on ClinicalTrials.gov,* a summary, including the following elements: study number, study period, design, methodology, indication and diagnosis, proper use instructions, inclusion and exclusion criteria, primary and secondary outcomes, baseline characteristics, number of patients screened/eligible/enrolled/lost to follow-up/withdrawn/analyzed, effectiveness/efficacy, and safety results.
- *A list of ongoing studies that your organization has sponsored for this indication.* In the list, please provide the *ClinicalTrials.gov* trial number or, if the trial is not registered, the protocol for the study including a study number, the study period, design, methodology, indication and diagnosis, proper use instructions, inclusion and exclusion criteria, and primary and secondary outcomes.
- Description of whether the above studies constitute *ALL Phase II and above clinical trials* sponsored by your

organization for this indication and an index outlining the relevant information in each submitted file.

Your contribution is very beneficial to the Program. Materials submitted must be publicly available or able to be made public. Materials that are considered confidential; marketing materials; study types not included in the review; or information on indications not included in the review cannot be used by the EPC Program. This is a voluntary request for information, and all costs for complying with this request must be borne by the submitter. The draft of this review will be posted on AHRQ's EPC Program website and available for public comment for a period of 4 weeks. If you would like to be notified when the draft is posted, please sign up for the email list at: *https://www.effectivehealthcare.ahrq.gov/email-updates.*

The systematic review will answer the following questions. This information is provided as background. AHRQ is not requesting that the public provide answers to these questions.

Questions for the Systematic Review

Question 1 (Scan). What approaches have been used to integrate behavioral health and primary care?

a. How do these approaches vary by:

(i) patient characteristics (*e.g.,* clinical focus/conditions/patient subgroups)
(ii) core components of the approach
(iii) practice/care delivery setting characteristics such as the policy environment, and geographic location.
(iv) resources and infrastructure required, such as staffing, payment models, financing, and technology
(v) mechanisms of care integration

Question 2 (Key). How effective are approaches to integrating behavioral health and primary care?

a. Does effectiveness vary by:

(i) patient characteristics (*e.g.,* clinical focus/conditions/patient subgroups)
(ii) core components of the approach
(iii) practice/care delivery setting characteristics, such as the policy environment, and geographic location.
(iv) resources and infrastructure required, such as staffing, financing, payment models, and technology
(v) mechanisms of care integration

b. How do interactions among the components of integration approaches impact effectiveness and maintenance of the integration of behavioral health and primary care?

Question 3 (Contextual). What are the barriers to and facilitators of implementing and sustaining different approaches to integrating behavioral health and primary care?

a. How do the barriers, facilitators, and other factors involved in the implementation of behavioral health and primary care interact to affect implementation and sustainability?

Question 4 (Contextual). What reliable, valid, clinically meaningful, and/or patient-centered measures and metrics are available to monitor and evaluate integration approaches?

a. How is measurement integrated into clinical care and the ongoing monitoring and evaluation of integration?

b. Are the measures or metrics specific to characteristics; level of complexity; or the structure, process, or outcomes of care integration?

c. Are there models or standards for how frequently the effectiveness of approaches to integration should be reassessed?

d. What are the gaps in measurement and what are the implications for our current ability to measure and assess integration?

Question 5 (Contextual). How are care team member roles and their work flows defined in different approaches to integrating behavioral health and primary care?

a. What training interventions (*e.g.,* mode and content, trainee credentials, dose and timing of training) are effective in facilitating integrated care team functioning?

POPULATION, INTERVENTIONS, COMPARATORS, OUTCOMES, AND SETTING (PICOS)

PICOS	Inclusion	Exclusion
Population	Children (aged 0–20 years) and adults (aged ≥21 years) with behavioral health needs. *Clinical focus/conditions including but not limited to patients with:* • Mental illness or mental health conditions • Substance use disorders • Stress-linked physical symptoms (*e.g.,* insomnia, fatigue) • Complex overlapping medical conditions and psychosocial risk factors • Experiences of trauma, adverse experiences, or stressful life events • Pregnant patients • Geriatric patients	• No exclusions for age or condition.
Intervention	Different approaches to integrating behavioral health and primary care services, including program/model components and strategies to integrate care. Examples of eligible programs/models for care integration include but are not limited to: • Collaborative Care Model • Primary Care Behavioral Health Model • Co-location models • Models that use telehealth for integration The baseline requirement is that the practice design of the approach facilitates interaction among primary care and behavioral health providers in the provision of care. Ongoing collaboration and coordination of care are required; activities may include screening and diagnosis, acute and long-term interventions, and follow up and maintenance.	• Co-location without collaboration. • Referral only (cold handoff). • Warm handoff without plan for continued communication and coordination of care. • Population level health promotion or prevention programs that are not individualized, integrated care (*e.g.,* Silver Sneakers). • Interventions for chronic medical conditions that do not include a significant, explicit behavioral health component.

POPULATION, INTERVENTIONS, COMPARATORS, OUTCOMES, AND SETTING (PICOS)—Continued

PICOS	Inclusion	Exclusion
Comparator	• Care as usual (*e.g.,* non-integrated behavioral health and primary care services) in a different group or time period • Alternative care integration strategy or strategies • No care	• No comparator for KQ 2 (descriptive studies; such as case studies). • Comparators not applicable to other questions.
Outcomes	Outcomes of interest include but not limited to: *PATIENT LEVEL* *Health outcomes:* • Morbidity • Mortality • Improved symptoms • Guideline concordant screening and diagnosis • Remission/recovery • Adherence to treatment *Patient Reported Outcomes:* • Health related quality of life • Functional status (including social and adaptive functioning) • Satisfaction with care *Measures of care utilization:* • Avoidable emergency care or inpatient care for behavioral health crises • Total health care utilization *Measures of access to care:* • Patients receive routine care as soon as wanted • Patients receive acute care when needed • Average wait time for BH • Patients experiencing difficulties or delays in obtaining BH care • Patients with mental health condition received treatment • Patients with SUDs received treatment *CLINICIAN AND PRACTICE LEVEL* *Clinician Outcomes:* • Clinician retention/turnover rates • Burnout • Professional satisfaction • Efficiency of clinician time use *Population/community/clinic panel health outcomes:* • BH-related preventive care measures • BH screening services *Cost outcomes:* • Cost per patient per year • Cost per service • Costs associated with care delays, fragmentation, poor coordination, redundancy, requested but not completed patient referrals *Implementation Outcomes:* • Adoption of intervention approaches • Fidelity • Systemic Change/Sustainment *HARMS* • Missed diagnoses • Delays in care • Overutilization of resources • Redundant or inappropriate care	Simulated results or responses to hypothetical scenarios or questions.
Setting	• Health systems/hospitals and community-based primary care practices in the United States (physical or virtual) or in countries with similar healthcare systems • Non-healthcare settings providing outpatient BH/PC (school-based clinics, community centers, churches, shelters) • Nursing homes, group homes and other long-term residential settings	• Hospitals. • Prehospital/EMS/crisis care. • Prisons. • Countries with healthcare systems that do not provide information relevant to the U.S.
Study Designs	• Experimental and observational studies that describe and evaluate integration approach. • For Scan Question 1 and Contextual Questions 3 and 5: Survey and Qualitative Studies. • For Contextual Question 4: Psychometric Studies • Systematic reviews that directly address one of the review questions	• Articles that do not include any data. • Proposals for approaches that have not been implemented. • Descriptions of approaches that have not been evaluated (for KQ2). • Articles reporting simulation or speculation.

Abbreviations: BH = behavioral health; EMS = emergency medical services; KQ = key question; PC = primary care.

Dated: October 17, 2022.

Marquita Cullom,

Associate Director.

[FR Doc. 2022–22843 Filed 10–20–22; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–23–23AH; Docket No. CDC–2022–0125]

Proposed Data Collection Submitted for Public Comment and Recommendations

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

ACTION: Notice with comment period.

SUMMARY: The Centers for Disease Control and Prevention (CDC), as part of its continuing effort to reduce public burden and maximize the utility of government information, invites the general public and other federal agencies the opportunity to comment on a proposed information collection, as required by the Paperwork Reduction Act of 1995. This notice invites comment on a proposed information collection project titled Community Health Workers for COVID Response and Resilient Communities (CCR) National Evaluation. This data collection will assess the activities implemented by the 68 recipients of the CDC–RFA–DP21–2109 CCR NOFO (CCR award recipients).

DATES: CDC must receive written comments on or before December 20, 2022.

ADDRESSES: You may submit comments, identified by Docket No. CDC–2022–0125 by either of the following methods:

- *Federal eRulemaking Portal: www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Jeffrey M. Zirger, Information Collection Review Office, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS H21–8, Atlanta, Georgia 30329.

Instructions: All submissions received must include the agency name and Docket Number. CDC will post, without change, all relevant comments to *www.regulations.gov.*

Please note: *Submit all comments through the Federal eRulemaking portal (www.regulations.gov) or by U.S. mail to the address listed above.*

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the information collection plan and instruments, contact Jeffrey M. Zirger, Information Collection Review Office, Centers for Disease Control and Prevention, 1600 Clifton Road, NE, MS H21–8, Atlanta, Georgia 30329; Telephone: 404–639–7118; Email: *omb@cdc.gov.*

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. In addition, the PRA also requires federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each new proposed collection, each proposed extension of existing collection of information, and each reinstatement of previously approved information collection before submitting the collection to the OMB for approval. To comply with this requirement, we are publishing this notice of a proposed data collection as described below.

The OMB is particularly interested in comments that will help:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
2. Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
3. Enhance the quality, utility, and clarity of the information to be collected;
4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submissions of responses; and
5. Assess information collection costs.

Proposed Project

Community Health Workers for COVID Response and Resilient Communities (CCR) National Evaluation—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

CDC is requesting a New Information Collection Request titled Community Health Workers for COVID Response and Resilient Communities (CCR) National Evaluation. In 2021, CDC funded DP21–2109, ''Community Health Workers for COVID Response and Resilient Communities (CCR)''. DP21–2109 funds 68 CCR recipients across the United States to train and deploy community health workers (CHWs) to support COVID–19 response efforts and to build and strengthen community resilience to fight COVID–19 through addressing existing health disparities. Thirty-two of the 68 recipients were funded for Component A, Capacity Building, which focuses on building capacity among CHWs, and 36 recipients are funded for Component B, Implementation Ready, which focuses on enhancing and expanding existing CHW efforts. DP21–2109 is funded for a three-year period, from September 2021 through August 2024.

CDC also funded CDC–RFA–DP21–2110, ''Community Health Workers for COVID Response and Resilient Communities (CCR)—Evaluation and Technical Assistance'' (CCR–ETA recipients) at the same time the agency funded DP21–2109. Two recipients were funded to design and conduct the national evaluation of DP21–2109 CCR and will lead the information collection described in this request.

The CCR National Evaluation aims to collect consistent, systematic information from the 68 CDC–RFA–DP21–2109 award recipients through two primary data collection efforts: (1) a CCR recipient survey; and (2) a survey of Community Health Workers (CHWs) funded through CCR. The CCR recipient survey will collect information about program management, organizational infrastructure, CHW implementation practices, populations of focus served by CCR funded efforts, non-CDC resources supporting the program, and other aspects of program implementation. The CHW survey will collect information about CHW roles, integration into community-based and care COVID response teams, core competency training, supervision, implementation activities, and compensation. The surveys will be administered by the CCR–ETA award recipients. Both surveys will be available in English and Spanish.

The goal of this data collection is to assess the activities implemented by the 68 recipients of the CDC–RFA–DP21–2109 CCR NOFO (CCR award recipients), as part of the three CCR core strategies (*i.e.,* CHW training, deployment, and engagement with COVID–19 response teams) and the intended outcomes of these activities on the CCR populations of focus. CDC will use resulting information to describe the