

FOR FURTHER INFORMATION CONTACT:

Theresa Kingsberry, Program Support Specialist, Federal Trade Commission Premerger Notification Office, Bureau of Competition, Room CC-5301, Washington, DC 20024, (202) 326-3100.

By direction of the Commission.

Donald S. Clark,

Secretary.

[FR Doc. 2017-02892 Filed 2-10-17; 8:45 am]

BILLING CODE 6750-01-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 (AHRQ REV)*.” In accordance with the Paperwork Reduction Act, AHRQ invites the public to comment on this proposed information collection.

DATES: Comments on this notice must be received by April 14, 2017.

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

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

FOR FURTHER INFORMATION CONTACT:

Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427-1477, or by emails at doris.lefkowitz@AHRQ.hhs.gov.

SUPPLEMENTARY INFORMATION:**Proposed Project**

The Re-Engineered Visit for Primary Care (AHRQ REV)

This project—The Re-engineered Visit for Primary Care (AHRQ REV)—directly addresses the agency’s goal to conduct research to enhance the quality of health care and reduction of 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 associated with medical errors 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 could potentially be avoided. The post-hospital discharge is a handoff ripe with hazards, potentially leading to an array of adverse events including the development of new or worsening symptoms, unplanned readmissions, and increased costs.

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 and handoffs to receiving providers or 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 for the primary care setting to reduce readmissions and improve patient safety are comparatively lacking, and this gap in the literature is becoming more pronounced as primary care is increasingly being called to serve as the key integrator role 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 that 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 a combination of qualitative research and quality improvement techniques 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 value 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 has 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 a site contact at each of the nine primary care practices. 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 what the work flow map looks like, setting a foundation for the actual work flow mapping process. We anticipate that eight individuals per primary care site will participate, for a total of 72 participants.

4. Process flow mapping: This collection will take place in a group meeting that brings together available 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 practices’ 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 have an initial process flow map on paper. We anticipate 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 failure modes identified in the process flow for the failure mode effects analysis. We anticipate that eight individuals per primary care site will participate, for a total of 72 participants.

6. Patient Interviews: As a complementary piece of research to the work flow mapping, there would also be a process flow map 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 and fail to plan accordingly in both hospital and primary care settings. 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, and Kaiser Permanente, among others. The patient interview is collecting unique information on the barriers to effective care transitions in the post-discharge period care, information which cannot be collected in other ways. Ten patients post-discharge from each of the nine primary care sites will be interviewed for a total of 90 patients.

7. Community agency interviews: As a complementary piece of research to the work flow mapping, the process flow map will reflect the perspective of community agencies affiliated with the primary care sites to assist patients. Five community agency representatives from each of the nine primary care sites 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/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 information identified from 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 that 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
Work flow mapping preliminary interview	72	1	0.5	36
Work flow mapping group interview	90	1	1.5	135
Work flow mapping follow-up interview	72	1	0.5	36
Patient interview	90	1	0.5	45

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS—Continued

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
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
Work flow mapping preliminary interview	72	36	^a 40.41	1,454.76
Work flow mapping group interview	90	135	^a 40.41	5,455.35
Work flow 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

^aParticipants 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 (\$15.01¹), Front Desk Staff (\$13.38²), Program Director (\$32.56), Pharmacist (\$56.96), Physician (\$91.60), Behavioral health provider (\$22.03).

^bBased upon the mean wages for consumers (all occupations).

^cBased upon the mean wages for Social Workers.

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. 2017-02893 Filed 2-10-17; 8:45 am]

BILLING CODE 4160-90-P

¹ <http://www.bls.gov/oes/current/oes319092.htm>.

² <http://www.bls.gov/oes/current/oes434171.htm>.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Disease Control and Prevention****Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Initial Review**

The meeting announced below concerns Innovative Internet-Based Approaches to Reach Black and Hispanic MSM for HIV Testing and Prevention Services, PS17-003; and Comparison of Models of PrEP Service Delivery at Title X and STD Clinics", PS17-004, initial review.

This document corrects a notice that was published in the **Federal Register** on January 25, 2017, Volume 82, page 8428. The meeting time and date should read as follows:

Time and Date: 10:00 a.m.–5:00 p.m., EST, February 22, 2017 (Closed).

Contact Person for More Information: Gregory Anderson, M.S., M.P.H., Scientific Review Officer, CDC, 1600 Clifton Road NE., Mailstop E60, Atlanta, Georgia 30329, Telephone: (404) 718-8833.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and

Prevention and the Agency for Toxic Substances and Disease Registry.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 2017-02880 Filed 2-10-17; 8:45 am]

BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Disease Control and Prevention****Board of Scientific Counselors, National Institute for Occupational Safety and Health: Notice of Charter Renewal**

This gives notice under the Federal Advisory Committee Act (Pub. L. 92-463) of October 6, 1972, that the Board of Scientific Counselors, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention, Department of Health and Human Services, has been renewed for a 2-year period through February 3, 2019.

For information, contact Paul J. Middendorf, Ph.D., Executive Secretary, BSC, NIOSH, CDC, 1600 Clifton Road NE., MS-E20, Atlanta, GA 30329-4018, telephone (404) 498-2500, fax (404) 498-2526.